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.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Illinois** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
HCBS Waiver for Adults with Developmental Disabilities

C. Waiver Number:IL.0350
Original Base Waiver Number: IL.0350.

D. Amendment Number:IL.0350.R03.01

E. Proposed Effective Date: *(mm/dd/yy)*

01/01/14

Approved Effective Date: 06/28/16
Approved Effective Date of Waiver being Amended: 07/01/12

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The State is seeking an amendment to make several changes to the approved waiver.

1) The State is requesting an increase in the capacity of the waiver. The increase is based upon State appropriations and in response to the Ligas Consent Decree, which is a law suit that targets adults with developmental disabilities living in private, State-funded Intermediate Care Facilities for Persons with Developmental Disabilities (ICFs/DD) who want to move to community-based services or settings and on behalf of adults with developmental disabilities living at home who want community-based services or settings.

2) The State seeks to add a new service called 24-hour Stabilization Service. Under this service, the Department of Human Services (OA) will develop through private contractors four, four-bed homes (for a total capacity of 16) to serve waiver participants who temporarily require stabilization services due to extreme behaviors.

3) The State seeks to raise the limit of Behavior Management Services from 66 hours to 104 hours per year. Additional hours (beyond 104) would be available with prior approval from the OA.

4) The State seeks to add Adults age 19-64 without dependent children and with income at or below 138% of the Federal Poverty Level. The Illinois General Assembly authorized Medicaid coverage for this group in the spring of 2013, with coverage beginning January 1, 2014. The Illinois Department of Healthcare and Family Services is working within federal guidelines to ensure that the service package for this new "ACA Adult" eligibility group includes state plan services. Additionally, HFS wishes to ensure that HCBS waiver services are available to persons in this group who require these services and who meet the waiver eligibility criteria. We are therefore proposing to add the ACA adult group to existing waivers that provide services of relevance to this population.

5) The State seeks to add Former Foster Care group defined as: young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits and are eligible for services regardless of income and assets. Eligibility for this group continues until the 26th birthday. The Illinois General Assembly authorized Medicaid coverage for this group in the spring of 2013, with coverage beginning January 1, 2014. The Illinois Department of Healthcare and Family Services is working within federal guidelines to ensure that the service package for this new Former Foster Care eligibility group includes state plan services. Additionally, HFS wishes to ensure that HCBS waiver services are available to persons in this group who require these services and who meet the waiver eligibility criteria. We are therefore proposing to add the ACA former foster care group to existing waivers that provide services of relevance to this population. The State of Illinois has eight HCBS waivers that will be amended to add the ACA Foster Care group.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☐ **Appendix A – Waiver Administration and Operation**	
☑ **Appendix B – Participant Access and Eligibility**	B-1 and E
☑ **Appendix C – Participant Services**	C-1
☐ **Appendix D – Participant Centered Service Planning and Delivery**	
☑ **Appendix E – Participant Direction of Services**	E-1
☐ **Appendix F – Participant Rights**	
☐ **Appendix G – Participant Safeguards**	
☐ **Appendix H**	
☐ **Appendix I – Financial Accountability**	
☑ **Appendix J – Cost-Neutrality Demonstration**	J-1 and J-

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☑ **Add/delete services**
- ☑ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☑ **Increase/decrease number of participants**
- ☑ **Revise cost neutrality demonstration**
- ☑ **Add participant-direction of services**
- ☐ **Other**

  Specify:

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

1. Request Information (1 of 3)

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. Program Title (*optional - this title will be used to locate this waiver in the finder*):
HCBS Waiver for Adults with Developmental Disabilities

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IL.0350
Waiver Number:IL.0350.R03.01
Draft ID: IL.026.03.01

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

E. Proposed Effective Date of Waiver being Amended: 07/01/12
Approved Effective Date of Waiver being Amended: 07/01/12

1. Request Information (2 of 3)

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 age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility 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 Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:
Not applicable.

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

- [ ] **Services furnished under the provisions of §1915(a)(1)(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)(2) (central broker)**
  - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
  - [ ] **§1915(b)(4) (selective contracting/limit number of providers)**
- [ ] **A program operated under §1932(a) of the Act.**

  Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
- [ ] **A program authorized under §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**
- [ ] **A program authorized under §1115 of the Act.**

  Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

- [x] **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

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 Waiver for Adults with Developmental Disabilities provides supports to eligible adults with developmental disabilities ages 18 and over. 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, including both budget and employer authority 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 personal support services provided by domestic employees or by employees of direct service providers. When participants exercise employer authority and hire domestic employees, the services of a Financial Management Services (FMS) entity are available. Participants also have a variety of therapies and other services available to them.

Residential service 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 Individual Service and Support Advocates (ISSA) employed by Independent Service Coordination (ISC) entities under contract with the Operating Agency.

Independent Service Coordination (ISC) entities under contract with the Operating Agency serve as the local point of access for adults with developmental disabilities.

In cooperation with the Illinois Department of Healthcare and Family Services (the State Medicaid Agency), the Illinois Department of Human Services, Division of Developmental Disabilities, functions as the Operating Agency (OA) to administer the Waiver for Adults with Developmental Disabilities.

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*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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 Improvement Strategy. Appendix H** contains the Quality Improvement 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)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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. *Specify 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 Act (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) age 21 and under and 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 frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including 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/IID.

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 §431.151, 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 Improvement**. 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 Improvement 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 in several ways. The OA kept the Statewide Advisory Council on Developmental Disabilities (SAC) informed and sought their comments. The OA received many public comments. In addition to reviewing the written comments received, the OA and MA met face-to-face with stakeholders including participants and family members, providers, advocates and other interested persons to discuss their comments. The OA posted the draft renewal application on its website with instructions to respond to the DDComments e-mail address.

The SAC is comprised of a direct consumer (or participant), a family member, and a provider elected from each of the regional 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 attend. During SAC meetings all members are welcome to provide individual comments as well as viewpoints from their own experiences and 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, standing and ad-hoc committees are formed as needed. Committees have a broad spectrum of membership that typically includes participants, family members, providers, trade group members, and other advocates.

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 is 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:

Last Name: Classen

First Name: Kris

Title: Manager, Long Term Services and Supports

Agency: Department of Healthcare and Family Services

Address: 401 S. Clinton, 4th Floor

Address 2:

City: Chicago

State: **Illinois**

Zip: 60607

Phone: (312) 793-0078 **Ext:** ☐ **TTY**

Fax: (312) 793-5278

E-mail: Kristopher.Classen@Illinois.gov

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

Last Name: Hoskin

First Name: Reta

Title: Associate Director

Agency:

	Department of Human Services
Address:	Division of Developmental Disabilities
Address 2:	319 E. Madison, Suite 3M
City:	Springfield
State:	**Illinois**
Zip:	62701
Phone:	(217) 782-9421 **Ext:** ☐ **TTY**
Fax:	(217) 558-2799
E-mail:	Reta.Hoskin@illinois.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:	Teresa Hursey
	State Medicaid Director or Designee
Submission Date:	Jun 21, 2016
	Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:	Hursey
First Name:	Teresa
Title:	Acting State Medicaid Director
Agency:	Illinois Department of Healthcare and Family Services
Address:	201 South Grand Avenue, East, 3rd Floor
Address 2:	
City:	Springfield
State:	**Illinois**
Zip:	62704
Phone:	(217) 782-2570 **Ext:** ☐ **TTY**
Fax:	

(217) 557-8604

E-mail: Teresa.Hursey@Illinois.gov

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Not applicable.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

This amendment was originally submitted prior to the 2014 deadline which required the inclusion of a Transition Plan. However, since the original submission, Illinois has complied with the requirement and on March 16, 2015, Illinois submitted its Statewide Transition Plan for compliance with HCBS final rules (2249-F and 2296-F) published on January 16, 2014 impacting this 1915c Medicaid waiver. These rules require States to ensure that individuals receiving Long-Term Services and Supports (LTSS) have full access to the benefits of community living and the opportunity to receive services in the most-integrated setting appropriate and those rights and privileges are comparable to those afforded to Non-Waiver participants in the community. Illinois' Statewide Transition Plan may be found at:
http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx

Illinois has embarked upon the processes identified in the Statewide Transition Plan to assure all residential settings and in particular, those settings that provide the service known as child group home comport with the federal rules. At the time of this submission, Illinois estimated 125 residential settings which fall under the service definition of Residential Habilitation

may likely require remedial action to assure compliance. This number crosses all of Illinois waivers. Additionally, a relatively small number, yet to be determined, may fall under the service definition of Developmental Training, as a non-residential service may also require remedial action to assure compliance.

The State intends to determine of the sites discussed above which may in actuality meet the federal requirements, require remedial action, or recommended to federal CMS for "Heightened Scrutiny" in WY 1. These determinations are to be made on a case-by-case basis and only after a site validation visit occurs. This process includes: 1) a participant survey to be distributed to site/setting participants and/or their representative; 2) a focus group or series of focus groups depending on the size of the site/setting with participants and/or their representatives; 3) meetings with key staff at the site/setting to review of the self-administered survey, internal policies and procedures and documentation of community integration; and 4) sample file reviews looking at individual participant's Plans of Care.

The State may request additional stakeholder feedback and documentation from the setting provider in order to make an informed decision regarding the status of the site in relationship to the regulations. For those adult day service settings that fall under the Heightened Scrutiny category, the State will forward this recommendation and the accompanying documentation to CMS.

If a site is determined through the heightened scrutiny process to not demonstrate the qualities of an integrated setting, the section of this renewal application addressing transition includes how the state will assure the health, welfare and safety of the participant to realize, to the best our abilities, a smooth and seamless transition.

The state assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ○ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:
Illinois Department of Human Services (DHS), Division of Developmental Disabilities

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-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. 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 (HFS), Illinois State Medicaid Agency, conducts the activities listed below. Unless otherwise specified below, the MA assesses the performance of the OA on a continuous and ongoing basis.

   The Medicaid Agency (MA) reviews and approves all changes to Medicaid policies, rules and regulations prior to implementation.
   The Medicaid Agency (MA) conducts all waiver appeal hearings and issues final determination decisions. The MA does not delegate this function to the Operating Agency. The MA provides independent, trained hearing officers for all appeal hearings.
   The Medicaid Agency reviews and approves changes to the Operating Agency s payment rate methodologies.
   .Annually, the MA conducts select reviews, including eight independent monitoring reviews as part of MA oversight.
   Annually, the Medicaid Agency participates jointly with the Operating Agency in select targeted reviews of a representative sample of participants, and by using performance measures and sampling described in Appendix A.
   .The Medicaid Agency participates in routine meetings with the OA to review and approve OA responses to substantiated Abuse, Neglect, and Financial Exploitation findings.
   . The Medicaid Agency receives all death reports from the OA.
   . The Medicaid Agency receives all reports of terminated and sanctioned providers.
   Annually, the Medicaid Agency conducts fiscal monitoring by conducting validation reviews from the Operating Agency post-payment reviews of a representative sample of participants, and by using performance measures and sampling described in Appendix A.

Staff from the Medicaid Agency are members of the Waiver Quality Management Committee (QMC), which meets quarterly. The committee is responsible for the overall coordination of quality management activities. Current members of the QMC include key staff from both the MA and the OA. This includes representatives from the MA Bureau of Interagency Coordination and the OA's Bureau of Quality Management, and the OA's Bureau of Program Development and Medicaid Administration. The committee is charged with reviewing data for the waiver performance measures, tracking the findings, and discussing strategies for remediation, both individual and systemic, based on the evidence presented.

Staff from the Medicaid Agency attends meetings of the Operating Agency's Statewide Advisory Council on Developmental Disabilities, with which all major initiatives and policy issues are discussed. The MA is not a formal member of the Statewide Advisory Council on DD but voluntarily participates as a way to keep informed of issues impacting individuals with DD being discussed by the council. The Statewide Advisory Council is not a policy-making body, but is advisory in nature and addresses all developmental disability issues including those services funded by Medicaid and those funded by other State sources. Medicaid Agency staff attempt to attend all Statewide Advisory Council meetings; however attendance is optional. Should an absence be necessary, a meeting summary is provided by the OA.

The Medicaid Agency participates with the Operating Agency in training and informational sessions.

Appendix A: Waiver Administration and Operation

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

   (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or 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.:*
   Independent Service Coordination (ISC) entities under contract with the Operating Agency, complete eligibility determinations, conduct monitoring functions and provide independent service coordination. These functions are done by Qualified Intellectual Disabilities Professionals (QIDPs) formerly known as Qualified Mental Retardation Professionals (QMRPs).

   The Operating Agency contracts with Financial Management Services (FMS) entities to provide supports to participants who exercise employer authority under this waiver. Please see Appendix E for more detailed information.

   In addition, the Operating Agency, at times, uses contracted vendors, selected in accordance with the State's procurement policies, to assist with functions related to consultation and technical assistance for establishing provider qualifications and establishing rate methodologies.

   ( ) **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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 (*Select One*):

   (●) **Not applicable**

   ( ) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

   [ ] **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

   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:

Appendix A: Waiver Administration and Operation

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.

Appendix A: Waiver Administration and Operation

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 contracted Independent Service Coordination (ISC) entities on an annual basis to ensure they are conforming to established standards. Operating Agency staff conduct annual on-site surveys that focus on compliance with the requirements of the OA□s screening manual and Individual Service and Support (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 (ISSA) process (documentation of required visits, participation in service plan development and approval, and annual re-determinations of eligibility).

Following each review, the ISC entities are notified by the Operating Agency in writing at the time of exit of any findings and are required to submit a corrective action plan, including timeframes for correction, for all findings. Providers must submit the corrective action plan to the OA within 14 calendar days of the exit and are required to develop a plan that will correct all findings within 60 calendar days. In instances of serious findings which raise concerns regarding a participant□s health, safety or welfare, the provider may be directed by the OA to correct a finding in a much shorter timeframe, including instances of immediate correction, where appropriate. Operating Agency staff review the corrective action plan and, if acceptable, approve it within 14 calendar days of receipt. If a corrective action plan is determined by the OA to be unacceptable, the provider is contacted and the problem(s) are explained. The OA works with the provider to develop an acceptable corrective action plan. In cases where the provider fails to submit a corrective action plan within the required timeframes and/or when the provider fails to submit an acceptable plan (following assistance from the OA), the OA develops and imposes a mandatory corrective action plan.

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

Appendix A: Waiver Administration and Operation

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. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	✓	✓	✓
Waiver enrollment managed against approved limits	✓	✓	
Waiver expenditures managed against approved levels	✓	✓	
Level of care evaluation	✓	✓	✓
Review of Participant service plans	✓	✓	✓
Prior authorization of waiver services	✓	✓	✓
Utilization management	✓	✓	
Qualified provider enrollment	✓	✓	
Execution of Medicaid provider agreements	✓	✓	✓
Establishment of a statewide rate methodology	✓	✓	
Rules, policies, procedures and information development governing the waiver program	✓	✓	
Quality assurance and quality improvement activities	✓	✓	✓

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.
   i. **Performance Measures**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
1A The Number and Percent of findings of noncompliance in the area of pre-admission screening & waiver enrollment with evidence of remediation within 90 days of discovery. N: Number of findings in these areas with evidence of remediation within 90 days of discovery. D: Number of findings in these areas where remediation was required.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☑ **Annually**

Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
2A Number and percent of semi-annual fiscal estimates where waiver enrollment, utilization and expenditures are less than or equal to the levels estimated in the approved waiver. N: Number of semi-annual fiscal estimates that were less than or equal to estimated levels. D: Number of semi-annual estimates.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MA MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Semi-Annually	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-Annually

Performance Measure:
3A Number and percent of findings of noncompliance in the area of level of care with evidence of remediation within 90 days of identification of the problem. N: Number of findings on level of care determinations with evidence of remediation within 90 days of discovery. D: Total number of findings of noncompliance in the area of level of care.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
4A Number and percent of findings of noncompliance in the area of service plans with evidence of remediation within 90 days of discovery. N: Number of findings of noncompliance on service plans with evidence of remediation within 90 days of discovery. D: Total number of findings of noncompliance in the area of service plans.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
5A Number and percent of findings of noncompliance in the area of provider qualifications with evidence of remediation within 90 days of discovery. N: Number of findings on provider qualifications with evidence of remediation within 90 days of discovery. D: Total number of findings in the area of provider qualifications.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
6A Number and percent of findings of noncompliance in the area of Medicaid Waiver provider agreement on file with the MA with evidence of remediation within 60 days of discovery. N: Number of findings in the area of Waiver provider agreements on file with the MA with evidence of remediation within 60 days. D: Total number of findings in the area of Waiver provider agreements.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MA MMIS

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
7A Number and percent of rate methodology changes approved by the MA and submitted for Public Notice prior to implementation by OA. N: Number of rate changes approved by the MA prior to implementation by the OA. D: Total number of rate methodology changes adopted.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

8A Number and percent of waiver program policies approved by the MA prior to OA dissemination and implementation. N: Number of waiver policies approved by the MA prior to dissemination. D: Total number of waiver policy changes implemented.

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**

☐ **Other**
Specify:

Performance Measure:
9A Number and percent of findings of noncompliance in the area of requests for services subject to prior authorization with evidence of remediation within 90 days of discovery. N: Number of findings in the area of services subject to prior approval with evidence of remediation within 90 days of discovery. D: Total number of findings in the area of prior authorization of services.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
OA database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
10A Number and percent of participant reviews conducted by the OA according to the sampling methodology specified in the approved waiver. N: Number of participant reviews conducted by the OA according to the sampling methodology in the waiver. D: Total number of participant reviews required according to the sampling methodology.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Medicaid Agency (MA) conducts select reviews as part of MA oversight and quality assurance.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Due to the administrative nature of the performance measures in this Appendix, remediation on delegated functions is conducted by the OA.

1A,3A,4A,5A,7A,8A,9A,10A: At quarterly Waiver Quality Management Committee (QMC) meetings, findings of noncompliance are discussed and the timeliness of remediation activities. System improvements are discussed by the MA and OA. As needed, a plan is developed to address areas of noncompliance. The Waiver QMC meeting summaries document planned actions to be taken to address findings. The Waiver QMC meeting summaries document the results of remediation activities and system improvement.

2A: Twice a year fiscal reports are reviewed and compared to estimates. When necessary, waiver amendments are discussed and prepared for submission by the MA.

6A: If the MA identifies providers without Medicaid Waiver agreements on file, the OA provides documentation of the signed agreement. If a provider agreement cannot be documented, a new provider agreement is obtained and claims are adjusted.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
The State has developed a Corrective Action Plan that is being incorporated into the waiver by reference. The OA is responsible for implementing the Plan. The MA will receive and review draft results from each step with sufficient time for comment before the due date.

Appendix B: Participant Access and Eligibility

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 one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☑ **Intellectual Disability or Developmental Disability, or Both**					
	☑	**Autism**	18		☑
	☑	**Developmental Disability**	18		☑
	☑	**Intellectual Disability**	18		☑
☐ **Mental Illness**					

	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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 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 Waiver does not serve individuals who need services solely due to physical conditions, but rather serves individuals with Intellectual Disabilities or conditions similar to Intellectual Disabilities, thus requiring an ICF/MR level of care.

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: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

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)*. Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **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.**

  Specify the percentage:

- ( ) **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.

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

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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:

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:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

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	19000
Year 2	19000
Year 3	19000
Year 4	20840
Year 5	20840

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	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

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).**

Purpose(s) the State reserves capacity for:

Purposes	
Ligas consent decree and State-Operated Developmental transitions	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Ligas consent decree and State-Operated Developmental transitions

Purpose *(describe):*

The purpose of the reserve capacity is to provide services to 800 participants in accordance with the Ligas consent decree and to provide services to participants transitioning to the waiver from State-Operated Developmental Centers.

Describe how the amount of reserved capacity was determined:

The amount of the reserved capacity was determined based on the terms of the Ligas consent decree and the State's plans to close one or more State-Operated Developmental Centers (SODC). One SODC is planned to close during WY1 (FY2013). Other downsizing plans are also in place for WY1. Estimates are based on closure and downsizing plans by the Operating Agency.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	800
Year 2	
Year 3	

Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

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.

The intake assessment tool and corresponding PUNS manual is available on the Operating Agency's website.

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 (DCFS) 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 (DHS), 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 Intellectual Disabilities who reside in State-Operated Mental Hospitals;
6) Individuals who reside in private ICFs/MR; and

7) Individuals with aging caregivers.

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 OA (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.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ○ **§1634 State**
   - ○ **SSI Criteria State**
   - ◉ **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - ◉ **No**
   - ○ **Yes**

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 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.**

Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **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)**
- [x] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

The state proposes to add:
1) Adults age 19 and above without dependent children and with income at or below 138% of the Federal Poverty Level (Adult ACA Population) as provided in Section 1902(a)(10)(A)(i)(VIII)of the Social Security Act (the Act) and Section 42 CFR 435.119 of the federal regulations.
2) Former Foster Care group defined as: young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits and are eligible for services regardless of income and assets pertaining to Title IV-E children under Section 1902(a)(10)(A)(i)(IX)of the Act and Section 42 CFR 435.150 of the federal regulations.

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)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the**

SSI program (42 CFR §435.121)

- ☐ **Medically needy without spenddown 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%.**

Specify percentage amount: [ ]

- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

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. 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:

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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 and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: SSI State or §1634 State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for

incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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 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: 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 the Independent Service Coordination (ISC) 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. In Illinois, QMRPs are referred to as Qualified Intellectual Disabilities Professionals

(QIDPs).

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. The manual is available on the Operating Agency's website.

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 applicants 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 applicants with Autism:
• Psychiatric evaluation by a licensed psychiatrist and a psychosocial assessment.

For all applicants:
• 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 State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the 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 Independent Service Coordination (ISC) entities that employ QIDPs (QMRPs) to complete the evaluations and reevaluations.

As part of the initial level of care determination process, staff 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 Intellectual Disabilities Professional (QIDP) reviews assessment results and other available information against the level of care criteria and guidance in the screening manual for developmental disabilities. The QIDP 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. Level of care determinations are transmitted electronically to the Operating Agency.

The re-determination process is essentially the same, except the ongoing level of care determination is based on a current ICAP, individual assessments and other information from the service planning process in conjunction with personal knowledge of the participant. Level 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 the other schedule:

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.**
  Specify the qualifications:

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. On-site reviews are done annually by the OA to ensure that documentation exists and coincides with the reevaluation date entered in the payment system. The payment edit has been found effective in providing an incentive for the contracted entities 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 §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Evaluation and reevaluation forms are kept by the Independent Service Coordination (ISC) contracted entities for the mandatory six years or more. Results are maintained electronically by the Operating Agency for three or more years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. **Sub-Assurances:**

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
11B Number and percent of new waiver participants who had a level of care assessment indicating need for ICF/MR level of care prior to receipt of services. N: Number of new waiver participants with a LOC assessment indicating need for ICF/MR prior to receipt of services. D: All new waiver participants.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
OA database of all new participants and date of LOC assessment.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
12B Number and percent of waiver participants where the participant was reassessed through the annual redetermination process of waiver eligibility within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC re-evaluation. N: Re-assessments completed within 12 months. D: Total number of participants due for waiver re-assessment.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
OA database on redetermination dates of completion

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
13B Number and percent of waiver participants' LOC initial determination/re-determination forms/instruments reviewed that are completed as required by the state. N: Number of LOC determinations/redeterminations completed as required by the state. D: Total number of LOC determinations reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
14B Number and percent of LOC determinations reviewed that were completed by a qualified evaluator. N: Number of LOC determinations that were completed by a qualified evaluator. D: Number of LOC determinations reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Medicaid Agency (MA) conducts select reviews as part of MA oversight and quality assurance.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
11B: The OA is responsible for individual remediation of findings where claims were submitted prior to initial LOC assessment. Remediation would include, upon discovery, voiding of prior claims.

12B: The OA is responsible for remediation of late redeterminations. Remediation would include, upon discovery, automatic withholding of payment to ISC entity until redetermination is completed, and monitoring that redetermination is completed.

13B, 14B: (Same as 21D) The OA is responsible for individual remediation. A POC is submitted by the provider to the OA for approval within 14 days of notification to provider of findings. The provider must correct the findings within 60 calendar days. In instances of serious findings the provider may be directed by the OA to correct a finding in a much shorter time frame, including instances of immediate correction, where appropriate. In instances where the provider fails to submit a POC or when the provider fails to submit an acceptable plan, the OA may develop and impose a mandatory POC.

The OA is responsible for the resolution of individual issues. The OA provides quarterly reports of individual remediation activities to the MA. Staff of the two State agencies review the reports on a quarterly basis as part of the Waiver Quality Management Committee (QMC) meetings. QMC meeting summaries document the findings and actions taken.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

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 QIDP/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 QIDP 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 non-verbal, the QIDP makes an accommodation. Acceptable accommodations may include use of staff with secondary language skills, translation services, oral assistance and communication devices.

The QIDP 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 including visits to the potential providers as indicated.

The IL 462-1238 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. The form is signed by the individual/legal representative. The form is available in

English and Spanish (IL 462-1238S).

b. **Maintenance of Forms.** Per 45 CFR §92.42, 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 IL 462-1238 forms are available in English and Spanish and are maintained by the Independent Service Coordination (ISC) contracted entity.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency 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 local ISC entities under contract with the Operating Agency serve as access points to the Waiver, and are integrated in their communities. On a daily basis the ISC entities 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 accessing services. Each of these information points is available in both Spanish and English. In addition, brochures and flyers are available in other languages including: Arabic, Bosnian, Chinese, Hindi, Khner, Korean, Polish, Russian, Urdu and Vietnamese.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. **Waiver Services Summary.** *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:*

Service Type	Service	
Statutory Service	**Adult Day Care**	
Statutory Service	**Developmental Training**	
Statutory Service	**Residential Habilitation**	
Statutory Service	**Supported Employment - Individual and Group**	
Extended State Plan Service	**Occupational Therapy (Extended Medicaid State Plan)**	
Extended State Plan Service	**Physical Therapy (Extended Medicaid State Plan)**	
Extended State Plan Service	**Speech Therapy (Extended Medicaid State Plan)**	
Supports for Participant Direction	**Service Facilitation**	
Other Service	**24-Hour Stabilization Services**	
Other Service	**Adaptive Equipment**	
Other Service	**Behavior Intervention and Treatment**	
Other Service	**Behavioral Services (Psychotherapy and Counseling)**	
Other Service	**Emergency Home Response Services (EHRS)**	
Other Service	**Home Accessibility Modifications**	
Other Service	**Non-Medical Transportation**	
Other Service	**Personal Support**	
Other Service	**Skilled Nursing**	
Other Service	**Temporary Assistance (formerly called Crisis Services)**	
Other Service	**Training and Counseling Services for Unpaid Caregivers**	

Other Service	Vehicle Modification

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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 service 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 Care center will be provided as a component of Adult Day Care (ADC) services. The cost of this transportation is included in the rate paid to providers of ADC 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 service planning team not to be appropriate because the participant is medically fragile.

For participants who choose participant-directed 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.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Care

Provider Category:
Agency

Provider Type:
Community-Based Agencies

Provider Qualifications

License *(specify)*:
89 Ill. Adm. Code 240

Certificate *(specify)*:

Other Standard *(specify)*:
59 Ill. Adm. Code 120
Contract with Department on Aging

Verification of Provider Qualifications

Entity Responsible for Verification:
Department on Aging and Waiver Operating Agency

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.

Frequency of Verification:
Department on Aging surveys are conducted once per contracting period (six years), with additional surveys conducted as necessary due to complaints or deficiencies. The OA verifies a contract with the Department on Aging upon enrollment and annually thereafter.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Statutory Service

Service:
Day Habilitation
Alternate Service Title (if any):
Developmental Training

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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 service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

Developmental Training 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 service plan. In addition, Developmental Training 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. The cost of transportation is included in the rate paid to providers of Developmental Training services. Training and assistance in transportation is provided as needed.

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

Documentation is maintained that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (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 supported employment; or

2) Payments that are passed through to users of supported employment services.

For participants who choose participant-directed 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.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Special Recreation Associations
Agency	Community-Based Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Developmental Training

Provider Category:

Agency

Provider Type:

Special Recreation Associations

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

59 Ill. Adm. Code 119 (Developmental Training)

Other Standard *(specify)*:

59 Ill. Adm. Code 50

59 Ill. Adm. Code 120

The Provider must have a current contract with the Operating Agency (OA) and meet all contractual requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (DHS)

Frequency of Verification:

Annual certification survey

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Developmental Training

Provider Category:

Agency

Provider Type:

Community-Based Agencies

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

59 Ill. Adm. Code 119 (Developmental Training)

Other Standard *(specify)*:

59 Ill. Adm. Code 50

59 Ill. Adm. Code 120

The Provider must have a current contract with the Operating Agency (OA) and meet all contractual requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (OA)

Frequency of Verification:

Annual certification survey

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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 care and protective oversight and supervision. Payment is not made for the cost of room and board. Included in the cost not covered are 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). Residential Habilitation includes the reduction of maladaptive behaviors through positive behavioral supports and other methods. Payment is not made, directly or indirectly, to members of the participant's immediate family. Transportation provided as a component part of Residential Habilitation is included in the rate paid to providers of Residential Habilitation services.

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.

Residential Habilitation sites are limited in size, depending on the licensure standards for the setting. Community Individual Living Arrangements (CILA) are limited in size to no more than 8 individuals. Community Living Facilities (CLF) are limited to no more than 16 individuals.

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.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies (CILA)
Agency	Community-Based agencies (CLF)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Community-Based Agencies (CILA)
Provider Qualifications
License *(specify)*:
59 Ill. Adm. Code 115 (Community Integrated Living Arrangements - CILA)
Certificate *(specify)*:

Other Standard *(specify)*:
59 Ill. Adm. Code 50
59 Ill. Adm. Code 120
59 Ill. Adm. Code 116
The Provider must have a current contract with the Operating Agency (OA) and meet all contractual requirements

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

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:
Community-Based agencies (CLF)
Provider Qualifications
License *(specify)*:

77 Ill. Adm. Code 370 (Community Living Facilities - CLF)
Certificate *(specify):*

Other Standard *(specify):*
The Provider must have a current contract with the Operating Agency (OA) and meet all contractual requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Public Health
Frequency of Verification:
Annual surveys and ongoing complaint investigations

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):
Supported Employment - Individual and Group

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition *(Scope):*
Supported Employment services consist of intensive, ongoing supports to participants who, because of their disabilities, need intensive ongoing supports to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of the service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Supported Employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job

development, negotiation with prospective employers, job analysis, job carving, training and systemic instruction, job coaching, benefits supports, training and planning, transportation, asset development and career advancement services, and other workplace support services including services not specifically related to job skill training than enable the participant to be successful in integrating into the job setting.

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 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:

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.

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

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

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

Supported Employment 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.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment - Individual and Group

Provider Category:

Agency

Provider Type:
Community-Based Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
59 Ill. Adm. Code 50
59 Ill. Adm. Code 120
The Provider must have a current contract with the Operating Agency (OA) and meet all contractual requirements.
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver Operating Agency (OA)
Frequency of Verification:
The OA verifies upon enrollment and conducts an annual review of contract continuation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Extended State Plan Service
Service Title:
Occupational Therapy (Extended Medicaid State Plan)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Occupational Therapy services under the waiver differ in nature and scope from Occupational Therapy services in the Medicaid State Plan. Waiver Occupational Therapy focuses on the long-term therapeutic 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 participant-directed 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.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Occupational Therapy (Extended Medicaid State Plan)

Provider Category:
Individual
Provider Type:
Occupational Therapist
Provider Qualifications
License *(specify)*:
225 ILCS 75/1 et seq.
68 Ill. Adm. Code 1315
Certificate *(specify)*:

Other Standard *(specify)*:
Occupational Therapist may directly supervise a Certified Occupational Therapist Assistant
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver Operating Agency and Medicaid Agency
Frequency of Verification:
The Operating Agency (OA) verifies upon enrollment, and the Medicaid Agency (MA) conducts a monthly verification of continuation of licensure.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Extended State Plan Service

Service Title:

Physical Therapy (Extended Medicaid State Plan)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope)*:

Physical Therapy services under the waiver differ in nature and scope from Physical Therapy services in the Medicaid State Plan. Waiver Physical Therapy focuses on the long-term therapeutic 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 participant-directed 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.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)*:

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Physical Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Physical Therapy (Extended Medicaid State Plan)

Provider Category:
Individual

Provider Type:
Physical Therapist

Provider Qualifications

License *(specify):*
225 ILCS 90/1 et seq.
68 Ill. Adm. Code 1340

Certificate *(specify):*

Other Standard *(specify):*
Physical Therapist may directly supervise a certified Physical Therapy Assistant.

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency (OA) and Medicaid Agency (MA)

Frequency of Verification:
The Operating Agency verifies upon enrollment and the Medicaid Agency conducts a monthly verification of continuation of licensure.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Extended State Plan Service

Service Title:
Speech Therapy (Extended Medicaid State Plan)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Speech Therapy services under the waiver differ in nature and scope from Speech Therapy services in the

Medicaid State Plan. Waiver Speech Therapy focuses on the long-term therapeutic 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 participant-directed 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.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Speech/Language Pathologist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Speech Therapy (Extended Medicaid State Plan)

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

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency (OA)and Medicaid Agency (MA)
Frequency of Verification:
The Operating Agency (OA) verifies upon enrollment and the Medicaid Agency (MA) conducts a monthly verification of continuation of licensure.

Appendix C: Participant Services

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 Type:

Supports for Participant Direction

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.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Service Facilitation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 (if applicable) to convene a service planning team, or may convene the team as directed by the participant or guardian (if applicable). The team consists of the participant, guardian (if applicable), family members and/or other individuals important to the participant, Service Facilitator, Individual Service and Support Advocate (ISSA), as well as any other professionals and service providers needed. Based on assessment information and discussions among members of the service planning team, the Service Facilitator develops/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 service 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, service plan and Service Agreements.

The Service Facilitator also assists the participant in determining whether 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:

Service Facilitation is only available to participants who are self-directing their waiver services.

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. For home-based supports participants, the individual service plan (ISP) and Service Agreement must set aside at least two hours per month to allow for routine required administrative activities.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-based agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Service Facilitation

Provider Category:
Agency
Provider Type:
Community-based agencies
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
The provider must have a current contract with the Operating Agency (OA) and meet all contractual requirements. The Provider shall not also provide Individual Service and Support Advocacy (ISSA). Services must be provided personally by a professional defined in federal regulations as a Qualified Mental Retardation Professional, known in Illinois as a Qualified Intellectual Disabilities Professional (QIDP).

Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver Operating Agency (OA)
Frequency of Verification:
OA verifies upon enrollment and conducts an annual review of contract continuation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

24-Hour Stabilization Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope)*:

24-Hour Stabilization Services are designed to meet the needs of participants who require short-term, temporary services outside of their existing homes. The service is directed at individuals who are experiencing acute behavioral conditions that result in difficulties in stabilization in the individuals' existing habilitation setting. Stabilization functions may include but are not limited to development of a sustainable behavior plan and interventions, implementation of positive and necessary behavior interventions, monitoring and tracking of individuals' behaviors, remediation of negative peer to peer interactions, resolution of other issues that are jeopardizing the individual's current service delivery, technical assistance to habilitation service providers serving the participant, and follow-up review on individual progress and phone consultation regarding remediation of identified issues.

24-Hour Stabilization Services providers must ensure that direct support staff working in the settings receives the basic direct support staff training that is required of all direct support staff in the Waiver plus an additional 20 hours of training targeting the unique needs of participants who seek the 24-Hour Stabilization Service. 24-Hour Stabilization Service providers will be required to submit their curriculum and show documentation of staff completion of this additional 20 hours of training. In addition, providers must document the credentials and experience of the trainer or trainers proposed by the provider and this documentation must be approved in advance by the Operating Agency.

The Operating Agency requires that the training is focused on initial and on-going safety and well-being of the individual (and other individuals and staff in the 24-Hour Stabilization Services homes) and specific program and behavioral needs of the individual to facilitate the individual's return to his or her previous setting or an appropriate alternative. Training topics for direct support staff include, but are not limited to:

• Welcome of the individual into the new temporary home
• Introduction of the individual to other individuals in the temporary home
• Building rapport/developing relationships with a strong positive philosophy of purpose and goals of the service encouraging safety, security, revised/modified plans of care and understanding of the participant's return to their previous residential setting
• Signs and symptoms of medication toxicity or non-therapeutic medication levels
• Recognizing, describing (verbally and in writing) and addressing escalating behavior

• Tension reduction and behavior de-escalation strategies using non-violent crisis management and intervention techniques that include how to deal with agitation, aggressiveness, crisis de-escalation
• Restraint techniques, if necessary (inclusive of physical, mechanical and chemical restraint) and nonphysical and verbal strategies for the prevention and risk reduction of crisis and other potential incidences of injurious situations
• Organizing meaningful structure of the day, evening and night, again with an emphasis on a strong positive philosophy of purpose and goals of the service directed at implementing a continuation of implemented strategies in the plan of care that follows the individual upon his/her return to the previous setting
• Aiding in return by the individual to the structure of the day, evening or night after escalation of behavior/de-escalation of behavior
• Aiding in return of the individual to his previous home or an appropriate alternative

This enhanced training with a curriculum and trainers approved by the Operating Agency is required in advance of service delivery in the 24-Hour Stabilization Services settings. Refresher training is required by the Operating Agency at least every two years after initial training inclusive of training topics which may be identified through the provider's program operations and provider or Operating Agency quality assurance activities.
The role of QIDPs requires active involvement with direct support staff including intensive data tracking and reporting, behavior modeling, team leadership, and post service progress. The individual QIDP ratio is 1 to 4.

Behavior therapy consultation is provided by Board-Certified Behavior Analysts as part of this service. This consultation includes such activities as training provider staff and family members/guardians in individualized behavioral analysis concepts, crisis intervention including formal recommendations of strategies and responses, demonstrating and modeling individualized techniques, educating staff regarding best practice methods as they may be relevant to specific individuals, developing individual-specific data collection and reporting systems, and monitoring individual service implementation and outcomes. Behavior plans are written by Board-Certified Behavior Analysts with consultation and coordination from the QIDPs. Each behavior plan developed will augment the existing behavior plan where appropriate and will address individuals' respective needs.

Providers must include nursing oversight, mental health expertise, when needed, coordination of ancillary services as part of this service, and ongoing dialogue and planning with other service providers for the participant to ensure a successful return to the former residential setting.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The services are temporary and short-term in nature. An individual will typically receive no more than 90 consecutive days of 24-Hour Stabilization Services, but may be approved for additional days by the Operating Agency. The initial goal of the Operating Agency is that these temporary services would last on average no more than 30 consecutive days per participant. 24-Hour Stabilization Services require prior approval by the Operating Agency.

The Operating Agency will establish and maintain four homes statewide for this service provision. Each home will have four single bedrooms.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Community Integrated Living Arrangement (CILA) agency under contract to provide 24-Hour Stabilization services.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: 24-Hour Stabilization Services

Provider Category:
Agency

Provider Type:
Licensed Community Integrated Living Arrangement (CILA) agency under contract to provide 24-Hour Stabilization services.

Provider Qualifications

License *(specify):*
CILA which must have a current license under ILCS 59:115.

Certificate *(specify):*

Other Standard *(specify):*
1) Must have a contract with the Operating Agency.
2) Providers will be selected through a Request For Applications process. No more than two providers will be selected.
3) The providers' homes must be accessible.

Verification of Provider Qualifications

Entity Responsible for Verification:
The Operating Agency (DHS) is responsible for verification of provider qualifications upon enrollment and on an ongoing basis.

Frequency of Verification:
The Operating Agency (DHS) verifies provider qualifications upon enrollment and on an ongoing basis

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Adaptive Equipment

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Adaptive Equipment, as specified in the service plan, 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 within the environment in which they live; and (c) such other durable equipment not available under the State Plan that is necessary to address participant functional limitations. The cost of the service may include training or technical assistance for the participant.

Assistive Technology is a device, 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 is 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 service plan.
5. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant in the operation and/or maintenance of the AT device.
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 in the operation and/or maintenance of the AT device.

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 assessment of the adaptive functioning needs of the participant and the indentification of 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.

Items reimbursed with Waiver funds do not include any Assistive Technology or Adaptive Equipment 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.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**

☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Equipment Vendors

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adaptive Equipment

Provider Category:
Agency

Provider Type:
Equipment Vendors

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Enrolled vendors approved by the Service Facilitator and participant or guardian, if one has been appointed.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Operating Agency (OA)

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Behavior Intervention and Treatment

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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 service 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 service plan and must be approved by the participant, guardian if one has been appointed, responsible QIDP/Service Facilitator, Individual Service and Support Advocate (ISSA) and the other members of the planning team. 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 service planning team at least every six months. This progress report is available to State staff upon request to evaluate the efficacy of the intervention and 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 Behavior Intervention and 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 participant-directed supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

There is a State fiscal year maximum of 104 hours with additional hours (beyond 104) available with prior approval from the Operating Agency.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Behavior Consultant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavior Intervention and Treatment

Provider Category:
Individual

Provider Type:
Behavior Consultant

Provider Qualifications

License *(specify):*
225 ILCS 15/1 et. Seq.
68 Ill. Adm. Code 1400

Certificate *(specify):*
Board Certified Behavior Analyst (at www.bacb.com)

Other Standard *(specify):*
1. Licensed clinical psychologist

2. Masters level professional who is certified as a Behavior Analyst by the Behavior Analyst Certification Board (bacb.com)

3. Bachelor's level professional who is certified as an Associate Behavior Analyst by the Behavior Analyst Certification Board (bacb.com)

6. Professional who is certified to provide Relationship Development Assessment. Information is at rdiconnect.com.

7. 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

Entity Responsible for Verification:
Waiver Operating Agency (AO) and the Medicaid Agency (MA)

Frequency of Verification:
Operating Agency (OA) verifies upon enrollment and verifies continuation of national certification (www.bcba).

Medicaid Agency conducts a monthly check for continuation of licensure for clinical psychologists.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Behavioral Services (Psychotherapy and Counseling)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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 participant-directed 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.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Psychotherapists
Individual	Licensed Counselors

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Services (Psychotherapy and Counseling)

Provider Category:
Individual
Provider Type:
Licensed Psychotherapists
Provider Qualifications
License *(specify):*
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
Certificate *(specify):*

Other Standard *(specify):*
Clinical Psychologist
Clinical Social Worker
Marriage/Family Therapist
Clinical Professional Counselor
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency (OA) and Medicaid Agency (MA)
Frequency of Verification:
Operating Agency (OA) verifies upon enrollment.

Medicaid Agency conducts a monthly check for continuation of licensure for licensed professionals.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Services (Psychotherapy and Counseling)

Provider Category:
Individual
Provider Type:
Licensed Counselors
Provider Qualifications
License *(specify):*
All licensure categories for psychotherapists, plus:
225 ILCS 20/1 et seq.
68 Ill Adm. Code 1470
225 ILCS 107/1 et seq.
68 Ill. Adm. Code 1375
Certificate *(specify):*

Other Standard *(specify):*
Social Worker
Professional Counselor

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency (OA) and Medicaid Agency (MA)
Frequency of Verification:
Operating Agency verifies upon enrollment.

Medicaid Agency conducts a monthly check for continuation of licensure for licensed professionals.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Emergency Home Response Services (EHRS)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Emergency Home Response Services (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 service plan, 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, have no regular companion and who would otherwise require extensive routine supervision.

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

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Emergency Home Response Services (EHRS)

Provider Category:
Agency

Provider Type:
Certified vendor

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Certified by the Department on Aging

Other Standard *(specify)*:
Annual written rate agreements with the Department on Aging and the OA.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department on Aging
Operating Agency (OA)

Frequency of Verification:
Initial Certification and recertification no less frequently than every three years by Department on Aging.

Upon enrollment and annual verification of Department on Aging written rate agreement by OA.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Home Accessibility Modifications

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

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

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Contractor
Agency	Construction Companies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Accessibility Modifications

Provider Category:
Individual
Provider Type:
Independent Contractor
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled vendor approved by the Service Facilitator and participant or guardian, if one has been appointed.
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver Operating Agency (OA)
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Accessibility Modifications

Provider Category:
Agency
Provider Type:
Construction Companies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled vendor approved by the Service Facilitator and participant or guardian, if one has been appointed.
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver Operating Agency (OA)

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Non-Medical Transportation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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 service 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 service plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Excluded is transportation to and from covered Medicaid State Plan services. Also excluded is transportation to and from day habilitation program services.

For participants who choose participant-directed supports, this service is included in the participant's monthly cost limit.

This service will not be duplicative of other services in the Waiver.

No more than $500 of the participant's monthly cost limit may be used for Non-Medical Transportation services. This limit was established through input from an external advisory committee of family representatives and is based on their opinions of individuals' and families' needs.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Special Recreation Associations
Agency	Public and private carriers
Agency	Community-based agencies
Individual	Individual Carriers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:
Special Recreation Associations
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Drivers must have appropriate state licenses and proof of insurance
Verification of Provider Qualifications
Entity Responsible for Verification:
Waiver Operating Agency (OA)
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency
Provider Type:
Public and private carriers
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Must meet existing requirements for public and private carriers

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Operating Agency (OA)

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Agency

Provider Type:
Community-based agencies

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Drivers must have appropriate state licenses and proof of insurance

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Operating Agency (OA)

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Non-Medical Transportation

Provider Category:
Individual

Provider Type:
Individual Carriers

Provider Qualifications

License *(specify)*:

Certificate *(specify):*

Other Standard *(specify):*
Drivers must have appropriate state licenses and proof of insurance

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Operating Agency (OA)

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Personal Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Personal Support services include:

• 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 function as 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 individual service 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.

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 service plan.
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, Developmental Training, etc., since the scope of Personal Support services are already included in those services.

This service is included in the participant's monthly cost limit. See Appendix C-4.

For participants still enrolled in secondary education, 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.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies and Special Recreation Associations
Individual	Personal Support Worker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Support

Provider Category:
Agency
Provider Type:
Community-Based Agencies and Special Recreation Associations
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The provider must have a contract with the Operating Agency (OA). Per contractual requirements, employees must complete Operating Agency-approved direct support personnel training program 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 (DSP).
All employees of the provider must pass required background checks including criminal background and Health Care Worker Registry checks prior to employment.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Operating Agency (OA)

Frequency of Verification:
OA verifies upon enrollment and conducts an annual review of contract continuation.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Support

Provider Category:
Individual

Provider Type:
Personal Support Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Aged 18 or older, and is deemed by the participant or guardian, if one has been apppointed, to be qualified and competent to meet the participant's needs and carry out responsibilities assigned via the service plan.

Workers hired on or after July 1, 2007, must have passed required background checks including criminal background and Health Care Worker Registry checks prior to employment.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial Management Service (FMS) entities and Waiver Operating Agency (OA).

Frequency of Verification:
Financial Management Service (FMS) entity verifies upon enrollment and Waiver Operating Agency conducts annual review of a representative sample.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Skilled Nursing

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope)*:

Services listed in the participant-centered service 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 participant-directed supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

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

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title

Individual	Registered Nurse; or Licensed Practical Nurse, under supervision by an RN

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual

Provider Type:
Registered Nurse; or Licensed Practical Nurse, under supervision by an RN

Provider Qualifications

License *(specify):*
225 ILCS 65/1 et seq.
68 Ill. Adm. Code 1300

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Operating Agency (DHS) and Medicaid Agency (MA)

Frequency of Verification:
The Operating Agency verifies upon enrollment and the Medicaid Agency conducts a monthly check for continuation of licensure for licensed professionals.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Temporary Assistance (formerly called Crisis Services)

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope):*
Temporary Assistance services (formerly called 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. Temporary Assistance services are not available for caregiver absences for vacations, educational or employment-related reasons, or other non-emergency reasons.

Temporary Assistance services include:

• 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 service plan.

Temporary Assistance may function as an extension of behavioral and therapy services. Extension of services means activities by the Temporary Assistance/Personal Support worker that assists 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.

Temporary Assistance 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.

Temporary Asssitance 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 Temporary Assistance and the scope of the needed services must be documented in the participant-centered service plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The rate, amount and frequency for this service must be specified in the Service Agreement(s) and in the individual service plan (ISP).

This service is not included in the participant's monthly home-based supports cost maximum.

Temporary Assistance services up to an additional $4000 per episode may be authorized for family emergencies subject to prior approval by the Operating Agency. Temporary Assistance 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. The limits were established through input from an external advisory committee of consumers, family members, providers, and other advocates and are based on their opinions of individuals' and families' needs.

This service is subject to prior approval by the Operating Agency. The Independent Service and Support Advocate (ISSA) or home-based supports Service Facilitator will submit a written request for prior authorization for Temporary Assistance services on behalf of the individual. The OA will respond in writing to the request

within 30 calendar days. However, when an unplanned need occurs, Temporary Assistance services may begin upon receipt of verbal approval from the OA. The OA will provide verbal approval ASAP but no later than 24 hours of receipt of request, in those cases of unplanned need. Subsequent written approval is issued to the participant, Service Facilitator and ISSA by the OA.

For young adults between age 18 and 22 who attend secondary education, Temporary Assistance services may not be delivered during the typical school day relative to the age of the participant or during times when educational services are being provided.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies and Special Recreation Associations
Individual	Temporary Assistance/Personal Support Worker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Temporary Assistance (formerly called Crisis Services)

Provider Category:
Agency

Provider Type:
Community-Based Agencies and Special Recreation Associations

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
The provider must be under contract with the Operating Agency. Per these contracts, employees must complete DHS-approved direct support personnel training program 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 (DSP).
All employees must pass required background checks including criminal background and Health Care Worker Registry checks prior to employment.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Operating Agency (OA)

Frequency of Verification:
The Waiver Operating Agency (OA) verifies upon enrollment and conducts an annual review of contract continuation.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Temporary Assistance (formerly called Crisis Services)

Provider Category:
Individual

Provider Type:
Temporary Assistance/Personal Support Worker

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Aged 18 or older and is deemed by the participant or guardian, if one has been appointed, to be qualified and competent to meet the participant's needs and carry out responsibilities assigned via the service plan.

Temporary Assistance workers hired on or after July 1, 2007, must pass required background checks including criminal background and Health Care Worker Registry checks prior to employment.

Verification of Provider Qualifications

Entity Responsible for Verification:
Financial Management Service (FMS) entities and Waiver Operating Agency (OA)

Frequency of Verification:
Financial Management Service entity verifies upon enrollment and the
Waiver Operating Agency (OA) conducts annual compliance review of a representative sample of participants.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:
Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Training and Counseling Services for Unpaid Caregivers

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Service Definition *(Scope)*:
Training and Counseling services are provided to 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 Waiver participant. Training includes instruction about treatment regimens and other services included in the support plan, use of equipment specified in the service plan, and includes updates as necessary to safely maintain the participant at home. All training for individuals who provide unpaid support to the participant must be included in the participant's individual service plan.

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 service plan. Counseling must be aimed at assisting the unpaid caregiver in understanding and meeting the needs of the participant.
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, the Adaptive Equipment/Assistive Technology service includes training for family members in the use and/or maintenance of the device, therefore, Training and Counseling could not cover this type of training.

This service may not be provided in order to train paid caregivers or school personnel.

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

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Training providers
Individual	Licensed counselors

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Training and Counseling Services for Unpaid Caregivers

Provider Category:
Agency
Provider Type:

Specialized Training providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Training programs, workshops or events deemed qualified by the participant/guardian (if one has been appointed) 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

Entity Responsible for Verification:

Waiver Operating Agency (OA)

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Training and Counseling Services for Unpaid Caregivers

Provider Category:

Individual

Provider Type:

Licensed counselors

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (OA)

Frequency of Verification:

Upon enrollment by the OA. The MA conducts monthly check for continuation of licensure.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modification

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 service 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 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.

The upkeep and maintenance of the modification is included in this service.

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 Habilitation and Developmental Training services.

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.

For participants who choose participant-directed 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.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Equipment Vendor and Installer

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modification

Provider Category:
Agency

Provider Type:
Equipment Vendor and Installer

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Enrolled vendor approved by the Service Facilitator and the participant or guardian, if one has been appointed.

Verification of Provider Qualifications

Entity Responsible for Verification:
Waiver Operating Agency (OA)

Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ( ) **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- (•) **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - [x] **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - [ ] **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

- [ ] **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- [x] **As an administrative activity.** *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 as an administrative activity from the local Independent Service Coordination (ISC) agency under contract with the Operating Agency (OA). ISSAs are Qualified Intellectual Disabilities Professionals (QIDP), who are responsible to conduct the annual re-determinations of level of care, participate in the service planning process, approve all participant-centered service plans, act as an independent advocate on behalf of the participant and family, visit with the participant at least four times per year to ensure health and welfare and that needs are being met, and alert the OA about issues that require additional monitoring and technical assistance. The ISC agency, as an independent entity, plays a key role in the State's waiver monitoring efforts.

In order to ensure onoing service delivery and oversight, case management services are also provided for each participant by a QIDP who is the employee of a direct service provider. The independent ISSA and the direct service provider case manager play distinct and complimentary roles in ensuring health and welfare and supporting participants in the community.

For individuals who exercise participant direction as part of home-based supports, Service Facilitation is a distinct waiver service included in the service cost limit, as defined in Appendix C.3. The Service Facilitator provides the participant and guardian, if one has been appointed, with information and assistance in support of participant direction. Participants have the choice of providers.

Other aspects of case management services are provided by QIDPs who are employees of direct service providers, including Residential Habilitation providers. The case management functions performed include coordination of multiple services and/or among multiple service providers and linking waiver participants to other Federal, state and local programs.

Some components of case management, including development and/or review of service plans, monitoring the implementation of service plans and participant health and welfare, addressing problems in service provision, and responding to participant crises, are provided under both the administrative and case management services. This is appropriate because the parties conducting the administrative functions are independent of direct services providers and play a role in the State's monitoring efforts. Direct case managers must also be involved in these issues in order to ensure appropriate service delivery.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

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):

- ( ) **No. Criminal history and/or background investigations are not required.**
- (•) **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):

Criminal background checks with the Illinois State Police are required for direct service staff hired by agencies providing Residential Habilitation 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 the conviction.

For individual providers hired as common law employees on or after July 1, 2007, the Financial Management Service (FMS) entity/entities under contract with the OA, is required to obtain criminal background checks and not enroll or retain independent personal support workers (common law employees or domestic employees) if the person has been convicted as described above. The FMS vendor obtains the criminal background check on behalf of all participants who hire independent personal support workers. The results are kept on file with the FMS entity.

When determining whether to grant a waiver for employees or potential employees found on the CANTS registry, the OA reviews applications for a waiver based on individual circumstances. The factors considered include, but are not limited to, the following:
-Circumstances surrounding the event,
-Work history of the employee requesting the waiver,
-Recommendation of employer or potential employer,
-The provider's quality review and licensure survey results,
-The length of time since the incident,
-The age of the employee at the time of the incident, and
-The results of a cross check in the Adult Registry.

Further, any waiver would be granted for the employee or potential employee while working for the provider involved in the waiver request only. Should the employee change providers, the decision whether to grant a waiver would be considered again.

Annually the OA reviews providers and FMS entities (for domestic employees) through a representative sample of participants for compliance with this requirement. These reviews consist of onsite documentation reviews of the results of the background checks maintained by the provider. As non-compliance with mandatory investigations is identified, corrective action plans, approved by the OA, are required to address findings.

The scope of the required investigations include an Illinois State Police criminal background check and a check of the Illinois Sex Offender Registry.

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):

○ **No. The State does not conduct abuse registry screening.**

◉ **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):

By statute, the Illinois Department of Public Health maintains an adult abuse and neglect registry. The registry is called the Healthcare Worker Registry (formerly known as the Nurse Aide Registry). 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).

Waiver providers are required by the OA to complete registry checks on all employees. Employees cannot be hired if they fail the registry checks. The results of the registry checks are documented by the provider.

Abuse/neglect screenings are required for all domestic employees hired on or after July 1, 2007, who provide Personal Support or Temporary Assistance services. Such individuals may not be employed in any capacity until the employer has checked the individual against the Ill. Department of Public Health, Health Care Worker Registry and the Ill. Department of Children and Family Services Registry. The FMS entities conduct the registry checks for all personal support workers employed directly by the participant or their representative.

Abuse/Neglect screenings are required for all individuals providing Residential Habilitation, Developmental Training, Supported Employment, Service Facilitation, Personal Support or Individual Service and Support

Advocacy (ISSA) services. Such individuals may not be employed in any capacity until the employer has checked the individual against:
• The Illinois Department of Public Health (IDPH) Health Care Worker Registry, and
• The Illinois Department of Children and Family Services (DCFS) State Central Register (Children's Abuse and Neglect Tracking System - CANTS).

If either database reports substantiated or indicated findings of physical or sexual abuse or egregious neglect, the person may not be employed.

When determining whether to grant a waiver for employees or potential employees found on the CANTS registry, the OA reviews applications for a waiver based on individual circumstances. The factors considered include, but are not limited to, the following:
-Circumstances surrounding the event,
-Work history of the employee requesting the waiver,
-Recommendation of employer or potential employer,
-The provider's quality review and licensure survey results,
-The length of time since the incident,
-The age of the employee at the time of the incident, and
-The results of a cross check in the Adult Registry.

Further, any waiver would be granted for the employee or potential employee while working for the provider involved in the waiver request only. Should the employee change providers, the decision whether to grant a waiver would be considered again.

The OA and the MA, through a representative sample, review providers and FMS entities for compliance with this requirement.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

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.**

◉ **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).**

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

Facility Type	
Community-Integrated Living Arrangement (CILA)	
Community -Based agencies (Community Living Facilities-CLFs)	

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 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 it is to ensure availability of supports to encourage individual choices about participating in specialized and generic 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 monitors support plans and ISSA visiting notes to ensure that community

integration is supported. Licensure standards are in place to ensure participants may maintain personal possessions, visit with friends in the community and be given the opportunity to develop social relationships and pursue hobbies and personal interests through participation in neighborhood, school and other community and other group activities.

Residential habilitation settings are community-based. They are located to promote easy access to resources and activities in the community such as stores, religious institutions, and services by foot, public transportation, or vehicle.

Consistent with each participant's service plan, the residential habilitation settings offer a home-like environment with access to kitchen facilities and small dining areas. They allow for privacy and visits from family and friends at times convenient to the participants and their visitors.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community-Integrated Living Arrangement (CILA)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
24-Hour Stabilization Services	✓
Speech Therapy (Extended Medicaid State Plan)	✓
Service Facilitation	
Physical Therapy (Extended Medicaid State Plan)	✓
Training and Counseling Services for Unpaid Caregivers	
Temporary Assistance (formerly called Crisis Services)	
Emergency Home Response Services (EHRS)	
Occupational Therapy (Extended Medicaid State Plan)	✓
Adaptive Equipment	✓
Home Accessibility Modifications	
Skilled Nursing	
Behavior Intervention and Treatment	✓
Personal Support	
Behavioral Services (Psychotherapy and Counseling)	✓
Adult Day Care	
Supported Employment - Individual and Group	
Developmental Training	
Non-Medical Transportation	
Residential Habilitation	✓
Vehicle Modification	

Facility Capacity Limit:

8

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : 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:

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.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community -Based agencies (Community Living Facilities-CLFs)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
24-Hour Stabilization Services	☐
Speech Therapy (Extended Medicaid State Plan)	☐
Service Facilitation	☐
Physical Therapy (Extended Medicaid State Plan)	☐
Training and Counseling Services for Unpaid Caregivers	☐

Temporary Assistance (formerly called Crisis Services)	☐
Emergency Home Response Services (EHRS)	☐
Occupational Therapy (Extended Medicaid State Plan)	☐
Adaptive Equipment	☑
Home Accessibility Modifications	☐
Skilled Nursing	☐
Behavior Intervention and Treatment	☑
Personal Support	☐
Behavioral Services (Psychotherapy and Counseling)	☑
Adult Day Care	☐
Supported Employment - Individual and Group	☐
Developmental Training	☐
Non-Medical Transportation	☐
Residential Habilitation	☑
Vehicle Modification	☐

Facility Capacity Limit:

16

Scope of Facility Sandards. For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☑
Physical environment	☑
Sanitation	☑
Safety	☑
Staff : 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:

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 CLF 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.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

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-1/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-1/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-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Parents, other relatives, and legal guardians may provide Personal Support, Temporary Assistance, and Non-

medical Transportation services. The relative or legal guardian must meet the same provider qualification criteria, and pass the required background checks, that are applicable to any provider rendering the same services.

Parents, other relatives, and legal guardians may not provide host family services (i.e., foster care and other shared living arrangements) under Residential Habilitation services. This prohibition is specified in Illinois Administrative Code, available upon request from either the Medicaid or Operating Agency.

Legally responsible relatives (i.e., spouses) may not be paid to provide waiver services, as specified in Appendix C-2(d) above.

The participant-centered support plan governs the services to be provided, including those provided by relatives and legal guardians. For participants who exercise employer authority, the Financial Management Service (FMS) entity receives time sheets detailing the date and time of services delivered. The FMS entity conducts routine quality assurance activities.

The OA through it's representative sample, reviews Personal Support, Temporary Assistance and Non-Medical Transportation, regardless of the provider relationship.

Payment arrangements to relatives and legal representatives may be reviewed and denied by the OA. Decisions to deny by the OA are subject to waiver appeal rights.

○ **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:

As part of the participant-centered planning process, participants in the Developmental Disabilities Adult Waiver and their guardian, if one has been appointed, together with the Service Facilitator or responsible QIDP, Individual Service and Support Advocate (ISSA), and other members of the service planning team, are responsible for selecting needed services and qualified service providers. If a qualified provider is selected who is not currently enrolled, the OA, in conjunction with the MA, enrolls the new provider. For participants or their guardian (as applicable), who choose to exercise employer authority, the Financial Management Service (FMS) entity assists with new provider enrollment.

Information on provider enrollment and required forms are posted on the OA's website. Copies of enrollment forms are available upon request. Information regarding provider qualifications and program guidelines is continuously available on the Operating Agency's website. A list of providers is posted on the OA's website. A hard copy of the listing is available upon request.

The State does not impose barriers to the free choice of willing and qualified providers.

The Operating Agency (OA) reviews and approves service providers for participation in the Adults with Developmental Disabilities Waiver based on the provider qualifications as specified in the Waiver.

The State Medicaid Agency enrolls all willing and qualified providers that are chosen by participants or guardian, if one is appointed, in the Adults with Developmental Disabilities Waiver. The MA maintains the waiver provider database.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
15C Number and percent of licensed or certified providers who meet initial licensure/certification standards. (Note: this covers licensed residential habilitation providers, certified day habilitation providers and licensed clinicians.) N: Number of newly enrolled licensed or certified providers who meet initial standards. D: Total number of newly enrolled licensed or certified providers.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
OA provider licensure and certification database

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
16C Number and percent of licensed or certified providers who continue to meet licensure/certification standards on an ongoing basis. (Note: covers the same providers as listed above.) N: Number of licensed or certified providers who continue to meet standards. D: Total number of enrolled licensed or certified providers.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
MA reviews all licensed clinicians. OA and MA merge and compare data for analysis and reporting purposes.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
17C The number and percent of non-licensed/non-certified providers reviewed, by provider type, who meet initial provider qualifications. (Note: Covers non-licensed behavioral therapists, transportation providers, supported employment providers, etc.) N: Number of non-licensed/non-certified providers who meet initial qualifications. D: Total number of newly enrolled providers.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
OA database on provider qualifications

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☑ **Annually**

Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
18C The number and percent of non-licensed/non-certified providers reviewed, by provider type, who continue to meet the waiver provider qualifications. (Note: Covers same providers as listed above.) N: Number of non-licensed/non-certified providers who continue to meet qualifications. D: Total number of enrolled non-licensed providers.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:
OA database on provider qualifications

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
19C Number and percent of independent personal support providers (domestic employees) screened by FMS vendors (on behalf of waiver participants who self-direct and exercise employer authority) who passed initial background and registry checks and thus were deemed eligible for hire. N: Number of domestic employees who passed initial checks. D: Total number of domestic employees hired.

Data Source (Select one):
Other
If 'Other' is selected, specify:
FMS vendor reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

☑ **Continuously and Ongoing**	☐ **Other** Specify:
☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
20C Number and percent of providers reviewed, by provider type, who meet waiver provider training requirements. N: Number of providers who met training requirements. D: Total number of providers subject to training requirements.

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Provider training compliance will be reviewed over the course of 5 years.
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Medicaid Agency (MA) conducts select reviews as part of MA oversight and quality assurance.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
15C, 16C, 17C, 18C: The OA is responsible for individual remediation which upon discovery includes: imposing sanctions, as appropriate, terminating provider agreements, and prohibition of new placements/enrollments.

19C: The OA is responsible for individual remediation which includes: upon discovery, completion of required checks by FMS entity and if eligible for hire, no further action. If not eligible for hire, notification to participant and provider termination of employment. Depending on the number of findings, a POC from the FMS entity may be required. If repeat findings and responsiveness to POC warrant further action, contract penalties will be imposed up to and including contract termination.

20C: The OA is responsible for individual remediation which includes, upon discovery, notification to provider out of compliance with training requirements. If provider comes into compliance, no further action is taken. If provider does not come into compliance, termination of waiver agreement with notification to affected participants. In some cases, a POC may be required.

The OA may impose sanctions on providers which fails to comply with conditions stipulated in the provider contract. Sanctions include, but are not limited to, payment suspension, loss of payment, and enrollment limitations, or other actions up to and including contract termination.

The OA provides quarterly reports of these remediation activities to the MA. Staff of the MA and OA review the reports which are documented in the Waiver Quality Management Committee (QMC) meeting summaries.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ( ) **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- (●) **Applicable** - The State imposes additional limits on the amount of waiver services.

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; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☑ **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.

1. In addition to the information contained in the OA's Waiver Manual, each participant receives an initial award letter that contains service limits.

The service limits are discussed verbally during the annual service planning process. The waiver case manager or Service Facilitator and the ISSA review service limits with the participant and guardian, if applicable. The written service plan is signed by the participant, or his or her guardian (if one has been appointed), the waiver case manager/Service Facilitator and the ISSA.

2. 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. Within the five-year maximum, there is also a $5,000 maximum per address for permanent home modifications for rented homes. 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 OA's Waiver manual.

3. Any combination of Developmental Training and Supported Employment services cannot exceed 1100 hours per year. This limit was established through a review of historical expenditures and is based on hours

of operation for day programs established in Illinois Administrative Code, Title 59, Chapter 1, Part 119.

4. Behavior Intervention and Treatment services cannot exceed 66 hours per year. These limits were established through a review of historical expenditures.

5. Any combination of Individual Counseling, Group Counseling, Individual Therapy, and Group Therapy cannot exceed a maximum of 60 hours per fiscal year. These limits were established through a review of historical expenditures.

☐ **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.

☐ **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.

The annual 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 based on Social Security benefit levels and are adjusted each January when Social Security benefits are adjusted for cost of living increases. 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 service plan of the participant within the program maximums. The annual service 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 (as applicable), Financial Management Service (FMS) entities, Service Facilitation providers and Individual Service and Support Advocacy (ISSA) agencies by the OA.

The monthly home-based support services budget limits, currently $2,094 for calendar year 2012 (or $1,396 if between the ages of 18 and 22 and still attending school), together with natural supports, general community resources, school-based services (for young adult participants still attending school), and Medicaid State Plan services are sufficient to meet the participant's needs. If the health and welfare of the participant cannot be assured on a long-term basis within the cost limit of home-based supports in combination wiht other natural supports and community resources, the participant will be considered for other service options within the Waiver, including residential service supports that are not participant-directed and some that are provided 24 hours a day, seven days a week. Pariticipants are notified of the opportunity to request a fairing hearing if enrollment is denied.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Residential habilitation services under this waiver are delivered in Child Group Home settings licensed by the State of Illinois, Department of Children and Family Services (the child protection agency in Illinois). The group homes are single family homes located in residential neighborhoods and are integrated into their community. Children attend school funded by the school district. The family scale homes provide family-style meals and age-appropriate activities based on the individual needs of each waiver participant. A Participant-centered Individual Service Plan is in place for each child.

The Operating Agency (DHS DDD) conducts annual site visits to each of the Residential Habilitation(residential) and Developmental Training (non-residential) providers in the waiver. Site visits are unannounced and comprehensive in nature. Results are discussed with the provider prior to exit and, depending on the nature of the findings, a plan of correction is required by the OA. Results from the collective site visits are reported on a quarterly basis to the Waiver Quality Management Committee which includes key staff from the MA (Dept. of Healthcare and Family Services).

In addition to annual monitoring by the OA, the OA also contracts with Independent Service Coordination (ISC) agencies who visit each child on a quarterly basis to ensure that the participant-centered service plan is being implemented and that the ongoing health, welfare and safety of the waiver participants are assured.

These group home settings were included as part of the recent survey conducted by an outside contractor (Univ. of Illinois at Springfield) to determine compliance with the new HCB setting requirements. The survey results are part of the Waiver Transition Plan submitted to CMS. Additional activities planned to verify the survey results and full compliance are outlined in the Waiver Transition Plan.
Also, key to our Statewide Transition are planned site visits to further address compliance that may be issues in Illinois statutes, rules, Medicaid authority and Operating entities policies, contracts, procedures, forms and the setting's internal policies and practices, all to ensure the highest level of compliance with rules relating to settings. The Illinois Transition Plan has timeline for all of these deliverables.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Referred to as Individual Service Plan (ISP)

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 *(select 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-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- [ ] **Social Worker**

  Specify qualifications:

- [x] **Other**

Specify the individuals and their qualifications:

For the participant-directed home-based supports, the Service Facilitator, who is a QIDP, is responsible. For those receiving Residential Habilitation services, the QIDP employed by the licensed provider, is responsible for service plan development.

Qualifications for Waiver case managers for Residential Habilitation providers and Service Facilitators are specified in Appendix C-1.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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:*

Participants are informed through the Rights of Individual Form (IL462-1201), shared and discussed annually with them by the Individual Service and Support Advocate (ISSA), that the provider employing the case manager/Service Facilitator may also provide direct services to participants. They are also informed through this form that it is the role of the ISSA, who is a QIDP employed by an Independent Service Coordination (ISC) entity under contract with the Operating Agency, to ensure the participants have free choice of providers and are given information about the full range of waiver services. The OA annually conducts on-site reviews of each ISSA agency, based on a statistically valid sample of participants, and ensures through interviews, observations, and documentation reviews, that the ISSAs are complying with this provision. Corrective action plans are required to be submitted to and approved by the OA for any identified findings.

In addition to the waiver case manager/Service Facilitator who is a QIDP employed by a direct service provider, all Waiver participants have an Individual Service and Support Advocate (ISSA). The ISSA participates in and approves the participant-directed individual service plan. The ISSA also conducts quarterly visits to the participant to ensure that services in the plan are being fully implemented and are meeting the participants' needs.

Through the ISSA, under contract with the OA, the State oversees the service plan process. In addition, the OA annually reviews the service plan process through a statistically valid sample of participants during on-site reviews. Any findings require a corrective action plan approved by the OA.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

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 individual service plans are developed by QIDPs, 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 and be agreed to by the participant or guardian (when applicable).

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

The participant or guardian (if one has been appointed), responsible waiver case manager/Service Facilitator, and the ISSA must approve the service plan, in writing.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

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
Within 30 days after the initiation of services, the responsible waiver case manager/Service Facilitator/QIDP shall prepare a written participant-centered service plan for each participant only after consultation with the following:
• Face-to-face consultation with the participant;
• Consultation with 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 service 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;
. Be based on assessed needs;
• 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 (if applicable)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 service 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 waiver case manager/Service Facilitator/QIDP; 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 waiver case manager/Service Facilitator shall make a referral to the Operating Agency for technical assistance and problem resolution.

The responsible waiver case manager/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.
All plans must be updated at least annually.

In developing, modifying, and evaluating the effectiveness of the plan, the responsible waiver case manager/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 his or her assessed needs; and
• Account for the following:
(i) the financial limitations of the participant, the provider, and funding sources;
(ii) the supports and training needed, offered, and accepted by the participant;
(iii) the participant's medical status,
(iv) the participant's ability to communicate his or her needs and preferences, and
(v) 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 identified limitations.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

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.

As part of the planning process with the participant and guardian (if one has been appointed), the responsible waiver case manager/Service Facilitator and ISSA are required to assess the potential risks to the health, welfare and safety of the participant. Guidelines on the minimum components of the risk assessment are contained in the Waiver Manual. The Waiver Manual is posted on the OA website and copies are available upon request.

The risk domains that must be assessed are: health/medical, safety (home), safety (community), safety (workplace), finances, behavioral and supports.

Strategies to mitigate risk must be incorporated into the service plan, including the consequences of choices that may involve risk, documenting the issues concerned and the decisions made. The team 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's or guardian's, if one has been appointed, history of decision-making and ability to learn from the natural negative consequences of 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.

Providers are free to select a commercially available assessment that includes an evaluation of risk or develop their own localized assessment-as long as the assessment includes the domains listed above and the minimum components described in the Waiver manual. Assessments must be performed at least annually or more frequently if indicated by the needs of the participant. When conducting risk assessments and making recommendations to mitigate risks, assessors should:

-Gather information from a variety of sources including the individual participant, guardian, family members, paid staff, record review, observation, and assessor direct knowledge of the individual.
-Recognize that some domains may not be applicable for all individuals. In such cases, the assessor should include a brief explanation of why the domain is not applicable and, therefore, no risks are evident.
-Provide narrative information (including brief overview of current skills as well as potential and known risks) sufficient to guide the interdisciplinary team. Consideration should be given to both the risks associated with current activities of the individual as well as potential risks which inhibit the indivdiual from pursuing his/her goals and fully participating in integrated settings.

Backup plans are developed, if it is determined to be necessary, as part of the plan development process.

If the participant is receiving services from an agency, the agency is required to provide back-up personnel as needed. When the participant is exercising employer authority, the back-up plan is specific to the participant's needs and may include family, other social service agencies, etc.

This waiver provides support services to adults of all ages, some of who live at home with other family members. As part of the service planning process, the participant or guardian, if one has been appointed, can make arrangements with multiple providers who can be contacted as needed.

A back-up plan is necessary when the absence of the service presents a risk to the health, welfare and/or safety of the participant. The planning team evaluates the need and type of back-up plan taking into consideration natural supports and available waiver services. Participants residing with family members can enter into agreements with providers that can provide services in an emergency situation or provide staff substitutes when regular staff cannot work assigned hours.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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.

A list of providers, by provider type, is available on the OA's website to assist in selecting qualified providers. A written list of providers is available upon request.

Participants are supported by the Independent Service Coordination (ISC) entity under contract with the Operating Agency. Once the individual or guardian expresses an interest in or selects the type(s) of services he or she wishes to receive, the ISC informs the individual or guardian of providers offering that type of service in the desired geographic area. ISCs will make referrals to those providers selected by the individual/guardian. These referrals must be documented on the DDPAS-10 form. The ISC ensures linkage with potential providers, and may, at the participant's request, participate in discussions or visits with providers. A copy of the DDPAS-10 form is maintained in the participant's file at the ISC entity's office.

On an ongoing basis and at least annually, the Individual Services and Support Advocate (ISSA) employed by the ISC, assists participants if they want to change providers. At any time, a participant may ask about other providers offering the types of services they are receiving in their geographic area. The service plan is updated when new providers are selected.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

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):

Annually OA staff review the adequacy of support plans through a representative sample during on-site reviews. The MA participates in select reviews. The reviews consist of record reviews, interviews with participants and staff, and direct observations.

Data from these reviews are aggregated by the OA and shared with the MA staff as part of the Waiver Quality Management Committee (QMC) meetings. This committee meets quarterly. In addition, the Medicaid Agency conducts select reviews as part of MA oversight and quality assurance.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

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 the other schedule:

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 §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☑ **Other**

Specify:

The responsible waiver case manager or Service Facilitator (for participant-directed support services) and ISSA, employed by an Independent Service Coordination (ISC) entity under contract with the OA maintain copies of the service plans. Copies of the service plans are maintained at the participant's residential setting (if receiving residential habilitation) and at the business locations of the case manager/Service Facilitator and ISSA.

Appendix D: Participant-Centered Planning and Service Delivery

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 waiver case manager/Service Facilitator is responsible for ensuring that the service plan is implemented and ensuring the ongoing health and welfare of the participant. They are required to have face-to-face contact with the participant at least six times per year, approximately one visit every two months.

The ISSA, who is independent of direct service provision, is responsible for monitoring the implementation of the service plan and ensuring the health and welfare of the participant. At least quarterly, the ISSA must visit with each participant in the Waiver.

The OA monitors the waiver case management/Service Facilitation and ISSA activity through review of a representative sample of participants on a continual basis. Data is collected and analyzed as specified under the Quality Improvement sections in Appendices D and G. Summary reports are shared with the MA quarterly and discussed during quarterly Wavier Quality Management Committee (QMC) meetings.

Following each review, providers are notified by the Operating Agency in writing at the time of exit of any findings and are required to submit a corrective action plan, including timeframes for correction, for all findings. Providers must submit the corrective action plan to the OA within 14 calendar days of the exit and are required to develop a plan that will correct all findings within 60 calendar days. In instances of serious findings which raise concerns regarding a participant's health, safety or welfare, the provider may be directed by the OA to correct a finding in a much shorter timeframe, including instances of immediate correction, where appropriate. Operating Agency staff review the corrective action plan and, if acceptable, approve it within 14 calendar days of receipt. If a corrective action plan is determined by the OA to be unacceptable, the provider is contacted and the problem(s) are explained. The OA works with the provider to develop an acceptable corrective action plan. In cases where the provider fails to submit a corrective action plan within the required timeframes and/or when the provider fails to submit an acceptable plan (following assistance from the OA), the OA develops and imposes a mandatory corrective action plan.

A representative sample of service plans are reviewed annually.

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 waiver case manager or Service Facilitator, the Individual Services and Support Advocacy (ISSA) entity, an Independent Service Coordination (ISC) entity under contract with the Operating Agency, continually (at least quarterly or more often if necessary) monitors the implementation of the plan and works cooperatively with the service providers, participant, and guardian (if one is appointed) 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 D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State

to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
21D Number and percent of participant individual service plans (ISPs) reviewed that address all participant needs identified by the assessment. N: Participant service plans that addressed all identified needs. D: All sample ISPs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☑ **Annually**

Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
22D Number and percent of satisfaction survey respondents sampled who report they receive services to address their needs. N: Number of respondents who reported they received services to address their needs. D: Total respondents sampled.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each*	**Frequency of data aggregation and analysis***(check each that applies):*

that applies):	
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
23D Number and percent of participants reviewed whose service plan have strategies to address all health and safety risks indicated in the assessment. N: Number of ISPs with strategies to address all identified health and safety risks. D: Total ISPs sampled with an assessed health and/or safety risk.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
24D Number and percent of ISP's that were developed in accordance with state requirements. N: Number of ISPs that were developed in accordance with state requirements. D: Number of ISPs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
25D Number and percent of waiver participants reviewed whose Individual Service Plan (ISP) was updated at least annually or more often when their needs changed. N: Number of ISPs that were revised at least annually or more often based on a change in the participant's needs. D: All participants in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
26D Number and percent of satisfaction survey respondents sampled who reported the receipt of all services listed in the service plan. N: Number of respondents who reported receipt of all services in their ISP. D: Total number of survey respondents.

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe

		Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
27D Number and percent of participants reviewed who received four quarterly visits from the ISC entity under contract with the OA to monitor that services are being delivered in accordance with the services in the plan of care. N: Number of participants who received 4 quarterly ISSA visits. D: Number of participants in sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
28D Number and percent of participants reviewed who received the services in the scope, amount, duration and frequency as specified in their individual service plan (ISP). N: Number of participants who received services as specified in their ISP. D: Number of participants reviewed in sample.

Data Source (Select one):
Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
29D Number and percent of waiver participant records reviewed with an appropriately completed and signed freedom of choice form that specified choice was offered between waiver services and institutional care at the time of enrollment. N: Number of participant records reviewed with choice form. D: Number of records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
30D Number and percent of records reviewed that document participants were informed at least annually of the right to choose their providers. N: Number of participant records reviewed that document participants were informed at least annually of the right to choose their providers. D: Number of sample records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
31D Number and percent of participants reviewed who were offered choice between/among waiver services (for which there has been a determination of need). N: Number of participants reviewed who were offered choice of waiver services. D: Total number of participants reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Medicaid Agency (MA) conducts select reviews as part of MA oversight and quality assurance.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
21D, 23D, 24D, 25D, 27-31D: The OA is responsible for individual remediation. A POC is submitted by the provider to the OA for approval within 14 days of notification to provider of findings. The POC must correct the findings within 60 calendar days. In instances of serious findings the provider may be directed by the OA to correct a finding in a much shorter time frame, including instances of immediate correction, where appropriate. In instances where the provider fails to submit a POC or when the provider fails to submit an acceptable plan, the OA may develop and impose a mandatory POC.

22D, 26D: Due to the nature of National Core Indicator (NCI) data being collected, no individual remediation is required for these measures. Guardian satisfaction surveys are anonymous. NCI data is a secondary data source for these measures.

The OA may impose sanctions on providers which fail to comply with conditions stipulated in the provider contract. Sanctions include, but are not limited to, payment suspension, loss of payment, and enrollment limitations, or other actions up to and including contract termination.

The OA provides summary reports of remediation activities to the MA. Staff of the MA and OA review the reports on a quarterly basis as part of the Waiver Quality Management Committee (QMC) meetings. QMC meeting summaries document findings and remediation activities.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **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: Participant Direction of Services

E-1: Overview (1 of 13)

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 waiver uses a participant-centered planning approach directly involving the participant and the participant's guardian (when applicable) as members of the service planning team along with the Waiver case manager or Service Facilitator, direct service providers, Individual Service and Support Advocate (ISSA) and any other persons important to the participant. For participants receiving participant-directed supports, the Waiver is designed to give participants budget authority and the ability to direct some or all of their services within established cost limits. In addition, participants may exercise employer authority to hire and fire independent providers (domestic employees). Financial Management Service (FMS) entities assist participants who opt to exercise employer authority by verifying employee requirements, processing timesheets, paying payroll and taxes, and tracking participant funds. There are currently two FMS entities available statewide.

During the initial service planning process, the participant and guardian (when applicable) receive information about participant-directed services and supports. Information is 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 the option to exercise budget authority up to the approved cost limits. Specific information is provided about the roles and responsibilities of the participant or legal representative as well as those of the Financial Management Service entity. Under employer authority, the OA provides information in the form of guidelines for hiring direct independent providers.

The participant's choice of the type of supports is documented as part of the participant-centered service plan. Service Agreements are completed for each provider selected by the participant. Service Agreements specify the name of the provider, the type of service provided, the rate of payment and the units of service to be provided. The Service Agreement is signed by the participant (or guardian, when applicable), the provider, and the Service Facilitator.

Participants selecting participant-directed services are assisted by the local Service Facilitator, the Individual Service and Support Advocate (ISSA) and the Financial Management Service (FMS) entity. Members of the support planning team are also available to assist the participant and/or legal representative (when applicable) in understanding and fulfilling their responsibilities.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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 these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select 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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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 Independent Service Coordination (ISC) 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 services.

Information is available for participants and guardians that include guidelines for selecting personal support workers as domestic employees, information on Financial Management Service (FMS) entities, rights and responsibilities, and other requirements of the Waiver. Information on the benefits and potential liabilities associated with participant direction is shared. The waiver case manager/Service Facilitator provides information to all participants when waiver services are initiated. The waiver case manager/Service Facilitator and the ISSA assist the participant to understand the service options available under the waiver. The information is reviewed with participants annually as part of the service planning process.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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 representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☐ **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:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Speech Therapy (Extended Medicaid State Plan)	☐	☑
Service Facilitation	☐	☑
Physical Therapy (Extended Medicaid State Plan)	☐	☑
Training and Counseling Services for Unpaid Caregivers	☐	☑
Temporary Assistance (formerly called Crisis Services)	☑	☑
Emergency Home Response Services (EHRS)	☐	☑
Occupational Therapy (Extended Medicaid State Plan)	☐	☑
Adaptive Equipment	☐	☑
Home Accessibility Modifications	☐	☑
Skilled Nursing	☐	☑
Behavior Intervention and Treatment	☐	☑

Personal Support	☑	☑
Behavioral Services (Psychotherapy and Counseling)	☐	☑
Non-Medical Transportation	☐	☑
Vehicle Modification	☐	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **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:

The State conducted a Request for Proposal (RFP) process to select Financial Management Service (FMS) vendor(s). The OA developed the RFP for the FMS Vendor Fiscal option pursuant to Section 3504 of the IRS Code, IRS Revenue Procedure 70-6, and IRS Proposed Notice 2003-70m as well as OA rules and regulations.

The criteria used in selecting the vendor(s) 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 per member per month (PMPM) fee is paid to the FMS private entities is established through the RFP process, a competitive bid process.

The PMPM fee, through this process, is negotiated for waiver participants between the State and the successful bidders. The fee is claimed as an administrative fee under the Waiver.

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:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

Assist with performing required background checks, abuse and neglect registry checks and any other required screenings. Verify independent Personal Support (domestic employee) provider qualifications.

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **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**
- [x] **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**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **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 FMS private entity(ies) 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 will monitor the vendor(s) based on the performance measures approved in the waiver and any other contractual requirements. The vendor(s) agrees to provide all of the data specified by the State for service payment and claiming purposes. The vendor(s) 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 reviews performance on an annual basis. The Medicaid Agency participates in the review and the results of these reviews are shared with the Waiver Quality Management Committee.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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 following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
24-Hour Stabilization Services	☐
Speech Therapy (Extended Medicaid State Plan)	☐
Service Facilitation	☑
Physical Therapy (Extended Medicaid State Plan)	☐
Training and Counseling Services for Unpaid Caregivers	☐
Temporary Assistance (formerly called Crisis Services)	☐
Emergency Home Response Services (EHRS)	☐
Occupational Therapy (Extended Medicaid State Plan)	☐
Adaptive Equipment	☐

Home Accessibility Modifications	☐
Skilled Nursing	☐
Behavior Intervention and Treatment	☐
Personal Support	☐
Behavioral Services (Psychotherapy and Counseling)	☐
Adult Day Care	☐
Supported Employment - Individual and Group	☐
Developmental Training	☐
Non-Medical Transportation	☐
Residential Habilitation	☐
Vehicle Modification	☐

☑ **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 ISC 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 service plan and approves the final plan, as well as monitors its implementation and the general health and well being of the participant. Annually the Operating Agency reviews ISSA entities using a representative sample of waiver participants.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **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:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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:

A participant or their guardian, if one has been appointed, may choose to voluntarily terminate from participant-direction at any time. If the participant exercised employer authority, employees of the participant are typically provided with 30 days advance written notice of the termination, however, this notificaton is not mandatory. The participant selects a community agency to provide and direct needed Waiver services. These changes are discussed among those responsible for service planning. The plan is updated to reflect the change in service delivery method, the participant's or guardian's (when applicable) decision to terminate participant-direction, and the selected community agency(ies) that will now be delivering services. The ISSA works with service providers, the Waiver case manager/Service Facilitator, and the Operating Agency as necessary to ensure service continuity and health and welfare during the transition.

If the health and welfare of the participant cannot be assured on a long-term basis within the cost limit of participant-directed supports in comination with other natural supports and community resources, the participant will be considered for other service options within the Waiver, including other residential habilitation options. These limits were established through a review of historical expenditures.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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 at any time the MA or the OA determines that the participant and/or his or her representative have committed fraud regarding participant-directed program funds, the participant may be involuntarily restricted from participant-directed services. This restriction of participant-directed services by the State is subject to appeal to the MA. The outcome of the appeal process is final. In this event, agency-directed services would be made available and documented in the service plan. The ISSA works with the service providers, the waiver case manager/Service Facilitator and the OA as necessary to ensure service continuity and health and welfare during the transition.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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		6000
Year 2		6000
Year 3		6000
Year 4		6000
Year 5		6000

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

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. *Select one or both*:

☐ **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. *Select one or more 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:

The cost of required background checks is paid by the OA as part of the negotiated per member per month (PMPM) fee paid to Financial Management Service (FMS) private entities.

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☑ **Determine staff wages and benefits subject to 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:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

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. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **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:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

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.

Within the overall home-based supports cost limit, the participant-centered service plan specifies the types of and amounts of covered services needed by the participant. For home-based supports, the maximum annual allocation is set by State law. At the time the law was passed, public hearings were held regarding its implementation. The annual allocation is tied to Social Security benefit levels which are indexed to the cost of living (as required by law).

Participants and the general public are made aware of the program budget amount in a variety of ways. For example, the Waiver Manual is available at the OA's website and contains this information. A Rate Table is also posted on the OA's website which outlines statewode rates for certain services. In addition, ISSAs and Service Facilitators assist individuals in understanding and working within the annual and monthly cost allocations.

Individuals may request a fair hearing of any denial or reduction in services. The Waiver Manual contains information on individual rights and fair hearings. Service Facilitators and ISSAs inform participants of their rights to appeal initially upon enrollment, annually as part of the service planning process and more often as needed.

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. A written Service Agreement is executed between each service provider, the participant or his or her quardian 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 Authorization for domestic employees is on file with the Financial Management Service (FMS) entity. Bills submitted in excess of the monthly and annual allocations are rejected for payment. This ensures that the combination of services received is consistent with the service plan and does not exceed the annual service cost limit.

The OA Rate Table is updated when rate adjustments are implemented, based on State appropriations.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

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 (when applicable) is informed in writing by the Operating Agency and in person by the ISSA about the overall cost limit, participant-directed opportunities, and budget authority. Once services have begun, the participant or guardian (when applicable) is notified and kept informed of any adjustments to the overall amount by the Operating Agency, Service Facilitator, and ISSA.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

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

○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**

◉ **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, when applicable, may adjust service plans 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 service plan. Changes in services are documented in the service plan and in revised Service Agreements. Changes in Service Agreements where the participant exercises budget authority are shared with the ISSA for monitoring purposes. Changes in Service Agreements where the participant exercises employer authority are shared with the Financial Management Service (FMS) entity when services provided by domestic employees

change.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

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:

Per statute, adult home-based supports spending is limited on a monthly basis. Participants are encouraged by members of the service planning team to allocate authorized services throughout the month to avoid premature depletion of program funds. Service facilitators closely monitor expenditures for services consistent with the service plan on a monthly basis. Edits in the electronic billing system prevent over expenditures.

Quarterly visits by the ISSAs, made to monitor service plan implementation and the participant's general health, safety and well being, identify and address issues of concern, including the timely prevention of the premature depletion of the participant-directed budget or potential service delivery problems.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 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:

The waiver case manager/Service Facilitator is responsible for informing individual participants of the right to appeal upon Waiver enrollment, annually as part of the service planning process and whenever an adverse action is taken.
•The Operating Agency (OA) has developed a standard form, Notice of Individual Right to Appeal (DD-1202) for this purpose. The form is available in English and Spanish.
•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. In other words, services will be continued if appealed within 10 days pending the results of the appeal process.
•The waiver case manager/Service Facilitator is responsible for maintaining notices of adverse actions and the opportunity to request a fair hearing.

Independent Service Coordination (ISC) entities under contract with the OA 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.

The waiver case manager/Service Facilitator is responsible for providing written notification to the participant when there is a denial, reduction, suspension or termination of service by the provider.

The Operating Agency (OA) and Medicaid Agency (MA) staff are responsible for written notification to the participant when there is an adverse decision in the Fair Hearing process.

Appeal Process

Participants (or his/her legal representative, when applicable) are informed by the Individual Service and Support Advocates (ISSA) employed by the ISC entities of appeal rights when Waiver services are initiated, and also upon notice of service denial, suspension, termination or reduction. Appeal rights are also available at any time upon request. The 89 Ill. Admin. Code 104 and the 59 Ill. Admin. Code 120.110 describe the Fair Hearing request procedures in use for the Waiver for Adults with Developmental Disabilities.

If participants receive notice of adverse action, they have 10 working days to file an appeal. If a participant is appealing termination of existing services and their appeal is filed timely, the services will continue until the conclusion of the appeal process. Once the appeal is filed, the OA 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 review, the participant and the service provider, if applicable, will be notified in writing of the decision within 10 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.

A Medicaid Agency hearing officer will conduct the hearing at the Medicaid Agency or OA office nearest to the family's home unless all parties agree to an alternate location. The participant, the hearing officer and a Medicaid Agency representative will participate in the hearing. The hearing officer may participate in person, by telephone or video conference.

During the hearing, the Medicaid Agency hearing officer will conduct the hearing in a fair and impartial manner. The hearing officer will allow the participant to present their case through documentary and testimonial evidence The Medicaid Agency representative will testify how they reached their decision and any supporting documents. The participant may question the Medicaid Agency representative. When the hearing is concluded, the Medicaid Agency hearing officer drafts a written recommended decision and sends it to the Medicaid Agency Hearing Supervisor for final review and sign-off by the Medicaid Director. The Medicaid Agency notifies the participant in writing as well as the OA of the final decision. The final administrative decision by the Medicaid Agency may be appealed to the State Circuit Court pursuant to the Administrative Review Law.

The Medicaid Agency rule (89 Ill. Adm. Code 104.70) provides that an appeal decision shall be given within 60 days of the date it was filed unless additional time is required, which may include postponement or continuance of a hearing for good cause as provided in 89 Ill. Adm. Code 104.45. The appeal process follows federally mandated rules that require all appeals to be treated equally and ensure due process is given for each appellant.

Training for the Medicaid hearing officers is conducted in several ways; by group training, one-on-one mentoring, and shadowing of experienced Medicaid hearing officers. Training encompasses training memos, conferences on administrative hearings, observing administrative hearings, review of previously conducted hearings, and the Medicaid waiver administrative codes and citations. All current HFS Medicaid Hearing Officers have experience in HFS programs—either Medical Programs or Child Support. Monitoring of the hearing process and final decisions occurs in several ways:

•The scheduling Medicaid Hearing Officer Supervisor creates a monthly report with the disposition of all cases to assure that hearings are being scheduled and moving through the process.

•Decisions go through three levels of HFS review:
1) the Medicaid Hearing Officer drafts the case
2) the Medicaid Hearing Supervisor reviews 100% of the cases
3) the Medicaid Director makes the final decision on every case

Quality Controls consist of reviewing cases for consistency in the application of the Medicaid laws and the use of sound legal reasoning. Trends and patterns are also considered as part of the quality oversight process.

Appendix F: Participant-Rights

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:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

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: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- ( ) **No. This Appendix does not apply**
- (●) **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**

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).

Upon enrollment and annually thereafter, participants and guardians are informed by the ISSA of their options for making complaints and that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing. The notification is documented in the Rights of the Individuals form (IL462-1201). Options for filing complaints are also posted on the OA's website.

Individuals have three options for making a complaint:

• contacting the Independent Service Coordination (ISC) entity,
• contacting the OA directly,
• and filing a report of abuse, neglect, or exploitation with the Office of Inspector General (OIG).

The participant, or guardian, if one has been appointed, may contact the OA directly at any time during the complaint process.

The type of complaints can include anything of concern to the participant or guardian, e.g., dissatisfaction with the participant's service plan, failure to implement the individual's service plan, quality of services or supports, concerns about the cleanliness or safety of the home, issues with peers, use of restraint, personal property matters, risk of losing services, etc. In addition, individuals may identify issues that are agency-wide and do not specifically apply to any individual or program site. Complaints involving allegations of abuse, neglect, or exploitation are routed directly to the Office of the Inspector General, regardless of the method used to make the complaint. Complaints exclude appeals for the denial, suspension, reduction or termination of services. Appeals should follow the appeal process outlined in the fair hearings section above.

When making a complaint, individuals may expect an initial response within two business days. In cases of reports of abuse, neglect, or exploitation, the initial contact will be within 24 hours.

Upon receipt of a complaint, the OA records the complaint in a database that documents the person making the complaint; the type of complaint; the substance of the complaint; the names of any participants, providers, and/or ISSAs involved; the person(s) at the OA assigned to review and address the complaint; action steps taken; final resolution; and dates of intake, action steps, and resolution. Reports are produced weekly for managers within the OA to ensure complaints are being addressed on a timely basis.

The data is analyzed and evaluated for trends on a quarterly and annual basis. The summary reports are shared with the MA. As individual problems and trends are identified, proactive remediation is initiated. Based on the data, the OA and MA may develop system improvement plans by identifying the responsibilities of the MA and OA and identifying time frames for completion. The Waiver Quality Management Committee (QMC) tracks all system improvement plans until completion. The QMC meets quarterly. The summary of the QMC meetings is a record of all system improvement actions taken.

Participants are informed annually through the Rights of Individuals form that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **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).

Currently the State requires the reporting of allegations of abuse, neglect, financial exploitation and deaths. In order to further enhance its critical incident management system, the State is submitting an Action Plan to CMS with the waiver renewal application. The Action Plan outlines the activities that the State is undertaking to enhance reporting and monitoring of critical incidents. The plan expands the types of reportable critical incidents. The Action Plan has been incorporated into the waiver by reference.

The remainder of this section addresses abuse, neglect, financial exploitation and deaths.

The State monitors that incidents of abuse/neglect/exploitation/death are identified and reported through the following activities:

• Identification of incidents during annual on-site reviews through the statistically valid sample of participants,
• Identification of incidents through the licensure/certification surveys, which are completed with each provider at a minimum every three years, but more frequently as detailed in Rule 115 based on the score level of the survey,
• Review of timely reporting during investigations by the Office of Inspector General, and
• Annual desk review to ensure all reportable deaths were reported and reported timely.

The State requires reporting of all allegations of abuse, neglect, financial exploitation and deaths occurring while the participant was present in an agency program (or within 14 days of discharge).

The Adults with Disabilities Domestic Abuse Intervention Act (20 ILCS 2435) and the Abused and Neglected Long Term Care Facilities Reporting Act (210 ILCS 30/6.2) set forth the reporting requirements for prevention of abuse and neglect for adults age 18 and older, as well as 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).

Under both laws, the types of critical incidents that must be reported to the OA Office of Inspector General (OIG) 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 where abuse is suspected must be reported. Serious injuries that require treatment by a physician or a nurse where abuse or neglect is suspected and must be reported. Medication errors that have an adverse outcome where abuse or neglect is suspected must be reported. Reportable medication errors are when the error results in the physical harm or mental deterioration of an individual or places an individual's health or safety at substantial risk.

Under 59 Ill. Adm. Code 50, deaths must be reported to the OA OIG if the death occurred while the individual was present in the community 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, or within four hours if abuse or neglect is suspected.

Required reporters under Rule 50 (agency programs) include all MA and OA staff and all community provider employees (including payroll employees, contractual employees, volunteers, and subcontractors). Required reporters must report allegations of abuse, neglect or financial exploitation within four hours of initial discovery by the required reporter. Required reporters must report allegations if they are told about abuse, neglect, or financial exploitation, if they witness it, or if they suspect it.

Anyone may make a report of alleged abuse, neglect or financial exploitation by calling the OA's Office of Inspector General 24-hour hotline (800)368-1463 (voice and TTY).

c. **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/or his or her guardian (if one has been appointed) are informed by the waiver case manager/Service Facilitator and the Individual Service and Support Advocate (ISSA) about protections from abuse, neglect, and financial 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 financial exploitation may report an allegation.

Information is provided in the Rights of the Individual form (IL462-1202) and is shared with the participant and guardian (if one has been appointed) upon enrollment and at least annually thereafter.

Information on the State's hotline is available on multiple websites and is also listed in the Waiver Manual (available on the OA's website). Instructions about reporting allegations, including the hotline, are also available on the OA website.

The OA monitors to assure that participants and guardians have received appropriate information about reporting allegations of abuse, neglect and financial exploitation.

d. **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.

The Operating Agency (DHS) Office of Inspector General (OIG), which is a semi-independent entity that reports to both the Governor and the Secretary of DHS (OA), has statutory authority to investigate alleged abuse, neglect and financial exploitation of adults with mental, developmental, or physical disabilities who reside in private homes or in

residential and other community settings funded by the OA.

For adults with disabilities who reside in private homes, the OA OIG has authority to investigate, take emergency action, work with local law enforcement authorities, obtain financial and medical records, and pursue guardianship. With the individual's consent, substantiated cases are referred to the OA for follow-up, or assessment of services.

The OA contacts the Independent Service Coordination (ISC) entity under contract with the OA which is required to visit the private homes and develop a plan of action. The plan is sent to the OIG. In instances where OIG makes a determination that the individual needs to be removed from the home, OIG contacts the OA by phone. The OA contacts the ISC entity and crisis services are provided.

When OIG receives an allegation of abuse, neglect or financial exploitation regarding an adult at a residential or other community setting funded by the OA, OIG determines whether to conduct an on-site investigation or assign investigation to the provider. OIG may assign primary responsibility to the provider only under the following conditions: if the allegation does not involve physical abuse, sexual abuse, or serious neglect; if the provider 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 the investigation decide to take over primary responsibility for the investigation. OIG also reviews each provider investigation and either approves it or returns it to the provider for additional work.

Regardless of the setting, the OIG shall initiate an assessment of all reports of alleged or suspected abuse, neglect or financial exploitation within 24 hours after the report is received.

Investigations must be completed and reports submitted by the OIG investigative bureau 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 guardian (if one has been appointed) 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
- The OA program division when investigative reports result in substantiated abuse, neglect or financial exploitation or recommend other administrative action.

The provider is required to inform the victim and the guardian 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.

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.

In order to further enhance its critical incident management system, the State is submitting an Action Plan to CMS with the waiver renewal application. The Action Plan outlines the activities that the State is undertaking to enhance reporting and monitoring of other types of critical incidents. The Action Plan has been incorporated into the waiver by reference.

e. 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.

The Operating Agency maintains a database of OIG allegations of abuse, neglect, financial exploitation and deaths and investigative findings.

If the OIG investigation substantiates abuse, neglect or financial exploitation, meaning a preponderance of the evidence supports that the abuse or neglect did occur, the provider is required to submit a Written Response within 30 days for approval by the OA . The Written Response must indicate what actions will be taken to address the issues identified. If a finding of physical abuse, sexual abuse or egregious neglect is substantiated, the perpetrator's name is placed on the Illinois Department of Public Health, Health Care Worker Registry.

The provider is required to inform the victim and the guardian 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.

The OA receives allegatons of abuse, neglect and financial exploitation from OIG as reported by complaintants to the OIG telephone hotline. These reports are received generally within 2 business days of the allegation being reported. Although OIG investigates, the OA program division reviews each allegation to determine whether action is warrented prior to completion of the OIG investigation.

The OA program division gathers information about the types of allegations, participant characteristics and providers to identify patterns and trends.

The OA program division monitors allegations on an ongoing basis. Summary and analytic reports are developed regarding allegations and findings. These reports are shared with the MA. Summary reports that do not contain confidential information are posted on the OA website.

Both the Medicaid Agency and the Operating Agency work together through the Waiver Quality Management Committee (QMC), which meets quarterly, to review performance measures on documentation of the notification to participants of the Rights of the Individual, the reporting of participant deaths, and critical incidents and follow-up methods.

In order to further enhance its critical incident management system, the State is submitting an Action Plan to CMS with the waiver renewal application. The Action Plan outlines the activities that the State is undertaking to enhance reporting and monitoring of other types of critical incidents. The Action Plan has been incorporated into the waiver by reference.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. 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). 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 Mental Health and Developmental Disabilities Code (405 ILCS 5/2-108) prohibits seclusion (time-out in a locked room).

Restraint may be used only as a therapeutic measure to prevent a participant from causing 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.

Providers are expected to teach appropriate alternative skills/behaviors to replace undesired behaviors, and use behavior intervention procedures that do not involve unnecessarily restricting the rights of waiver participants. Positive and reinforcing interactions between individuals and staff are the preferred method for reducing and/or eliminating undesired behavior in community programs. If less restrictive interventions fail or are not effective in preventing an individual from causing harm to self and others and the use of restrictive interventions is determined warranted, then the use of restrictive interventions is permitted as follows.
1) A behavior plan must be developed by the community support team.
2) The team discusses the proposed measures, identifying the risks and benefits.
3) The team confirms that the benefits of the proposed restrictive intervention outweigh the risks involved.
4) The plan is reviewed by the provider's behavior management committee, if one is in place.
5) In all cases, the plan is reviewed and approved by the provider's human rights committee prior to implementation.

The planning process must include documentation of prior attempts to use less restrictive or positive interventions and reason 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.

As part of the planning activities, the provider must develop a plan to reduce the reliance on restrictive interventions.

Examples of types of restrictive interventions that are permitted include:
-Personal restraint
-Time-out
-Psychotropic medications
-Restricted access to personal property, and
-Enhanced supervision

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, after personally observing and examining the participant, the physician, clinical psychologist, clinical social worker, or registered nurse 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 a restraint continue for longer than two hours unless within that time period a nurse or 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, clincial psychologist, clincal social worker, or registered nurse with supervisory responsibilities is not immediately available. In that event, an order 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 providers's chief executive officer or his/her designee in writing of the use of restraint within 24 hours. The chief executive officer or his or her designee 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 written authorization of the chief executive officer or his or her designee.

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 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 of time 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 or her right to have any person of his or her 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 or her choosing be notified of the restraint whether or not the guardian approves of the notice.

Service Planning Team Approval

Any restrictive intervention employed must be included in the participant's service plan and be approved as documented by signature of the participant or guardian (if one has been appointed), the responsible waiver case manager/Service Facilitator, the Individual Service and Support Advocate (ISSA), and other members of the service planning team. This planning process must include prior attempts to use less restrictive or positive interventions and reason 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 waiver case manager/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

Providers are required to establish and maintain a human rights committee that is responsible for reviewing and approving any restrictive intervention of a participant's rights, whether general rights or specific to behavior management. The committee must have at least five members. Membership must include:
- person served by the provider and/or his or her family member or guardian,
- interested citizens with no conflict of interest, and
- provider employee(s).

No more than half of the members of the committee may be employed by the provider and at least one third of the members must be otherwise unassociated with the provider.

The provider 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 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 experiences 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 overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Operating Agency is responsible for overseeing the permitted use of restraints and ensuring that State safeguards concerning their use are followed.

The OA contracts with waiver case manager/Service Facilitation providers and Independent Service Coordination (ISC) agencies to monitor the unauthorized use of restraints and restrictive intervention of participants. The waiver case manager/Service Facilitator visits at least monthly for residential and at least every two months for participants receiving participant-directed supports. The Individual Service and Support Advocate (ISSA) conducts quarterly visits. Both the local waiver case manager/Service Facilitator and the ISSA are QIDPs and are subject to mandatory reporting requirements.

The waiver case manager/Service Facilitator (through required visits) and ISSA's (through at least quarterly visits) monitor through on-site observations, interviews, and record reviews. Any potential abuse would be reported to the OIG.

Any findings of unauthorized use of restraint and seclusion, or of injuries to participants resulting from the use of restraint regardless of authorization, are required to be reported by the ISC entities to the OA via the OA's referral form. The referral must be sent to the OA within two business days. Findings are documented on the ISSA Visiting Notes form, discussed with the provider and addressed as necessary. Addressing the findings may include reporting potential abuse to the appropriate entity (Office of Inspector General), working with the provider to develop or modify behavior plans and/or any additional action that may be appropriate to the specific circumstances.

The OA tracks and analyzes reports received from ISSAs. The OA monitors both the provider and ISSA activities thorough these reports, identifies additional remediation needs, and develops and implements systemic changes when necessary.

The OA monitors through a representative sample of participants on a continuous and ongoing basis. On-site reviews consist of record reviews, interviews with participants and staff, and observations.

Identification of any unauthorized use of restraint or seclusion by a provider is subject to corrective action.

The OA collects data on the reporting of critical incidents and restrictive interventions as outlined in Appendix G - Performance Measures. The data is summarized and presented at the Waiver Quality Management Committee (QMC) meetings. The QMC meets quarterly. The MA and the OA reviews summary data, remediation activities and identifies trends over time as well as the effectiveness of policies and procedures.

In order to further enhance its critical incident management system, the State is submitting an Action Plan to CMS with the waiver renewal application. The Action Plan outlines the activities that the State is undertaking to enhance reporting and monitoring of critical incidents. This will include unauthorized restraint and seclusion. The Action Plan has been incorporated into the waiver by reference.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Operating Agency is responsible for detecting the unauthorized use of restrictive interventions and ensuring that State safeguards concerning their use are followed.

The OA contracts with waiver case manager/Service Facilitation providers and Independent Service Coordination (ISC) agencies to monitor the unauthorized use of restraints, seclusion and restrictive intervention of participants. The waiver case manager/Service Facilitator visits at least monthly for residential and at least every two months for participants receiving participant-directed supports. The Individual Service and Support Advocate (ISSA) conducts quarterly visits. Both the local waiver case manager/Service Facilitator and the ISSA are QIDPs and are subject to mandatory reporting requirements.

The waiver case manager/Service Facilitator (through required visits) and ISSA's (through at least quarterly visits) monitor through on-site observations, interviews, and record reviews. Any potential abuse would be reported to the OIG.

Any findings of unauthorized use of restraint, seclusion and restrictive interventions, or of injuries to participants resulting from the use of restraint regardless of authorization, are required to be reported by the ISC entities to the OA via the OA's referral form. The referral must be sent to the OA within two business days. Findings are documented on the ISSA Visiting Notes form, discussed with the provider and addressed as necessary. Addressing the findings may include reporting potential abuse to the appropriate entity (Office of Inspector General), working with the provider to develop or modify behavior plans and/or any additional action that may be appropriate to the specific circumstances.

The OA tracks and analyzes reports received from ISSAs. The OA monitors both the provider and ISSA activities thorough these reports, identifies additional remediation needs, and develops and implements systemic changes when necessary.

The OA monitors through a representative sample of participants on a continuous and ongoing basis. On-site reviews consist of record reviews, interviews with participants and staff, and observations. Identification of any unauthorized use of restraint, seclusion or restrictive intervention by a provider is subject to corrective action.

The OA collects data on the reporting of critical incidents and restrictive interventions as outlined in Appendix G - Performance Measures. The data is summarized and presented at the Waiver Quality Management Committee

(QMC) meetings. The QMC meets quarterly. The MA and the OA reviews summary data, remediation activities and identifies trends over time as well as the effectiveness of policies and procedures.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

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.

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:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Operating Agency is responsible for detecting the unauthorized use of seclusion and ensuring that State safeguards concerning their use are followed.

The OA contracts with waiver case manager/Service Facilitation providers and Independent Service Coordination (ISC) agencies to monitor the unauthorized use of restraints, seclusion and restrictive intervention of participants. The waiver case manager/Service Facilitator visits at least monthly for residential and at least every two months for participants receiving participant-directed supports. The Individual Service and Support Advocate (ISSA) conducts quarterly visits. Both the local waiver case manager/Service Facilitator and the ISSA are QIDPs and are subject to mandatory reporting requirements.

The waiver case manager/Service Facilitator (through required visits) and ISSA's (through at least quarterly visits) monitor through on-site observations, interviews, and record reviews. Any potential abuse would be reported to the OIG.

Any findings of unauthorized use of restraint and seclusion, or of injuries to participants resulting from the use of restraint regardless of authorization, are required to be reported by the ISC entities to the OA via the OA's referral form. The referral must be sent to the OA within two business days. Findings are documented on the ISSA Visiting Notes form, discussed with the provider and addressed as necessary. Addressing the findings may include reporting potential abuse to the appropriate entity (Office of Inspector General), working with the provider to develop or modify behavior plans and/or any additional action that may be appropriate to the specific circumstances.

The OA tracks and analyzes reports received from ISSAs. The OA monitors both the provider and ISSA activities thorough these reports, identifies additional remediation needs, and develops and implements systemic

changes when necessary.

The OA monitors through a representative sample of participants on a continuous and ongoing basis. On-site reviews consist of record reviews, interviews with participants and staff, and observations. Identification of any unauthorized use of restraint or seclusion by a provider is subject to corrective action.

The OA collects data on the reporting of critical incidents and restrictive interventions as outlined in Appendix G - Performance Measures. The data is summarized and presented at the Waiver Quality Management Committee (QMC) meetings. The QMC meets quarterly. The MA and the OA reviews summary data, remediation activities and identifies trends over time as well as the effectiveness of policies and procedures.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of 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).

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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:

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

◉ **Yes. This Appendix applies** *(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.

A physician shall be responsible for the medical services provided to participants and the management of participants' medications.

59 Ill. Adm. Code 116 requires that Residential Habilitation 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 (MAR) 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.

Licensing rule 89 Ill. Adm. Code 115 requires that participants in the residential setting who are receiving prescription medications must be seen by the prescribing physician every six months to review the medication use, and every three months if receiving psychotropics. A psychiatrist will either review psychotropic

medications or be available for consultation when psychotropic medications have been prescribed.

A physician or pharmacist shall make available to employees, family and participants information on expected consequences, potential benefits and side effects of any prescribed medication.

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 a person trained in performing this type of assessment.

Use of medications to modify or control behaviors or treatment of mental illness 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.

Residential providers subject to medication administration requirements are monitored by the OA for compliance. Providers are required to track all medication errors and to report to the OA all errors with an adverse outcome (defined as requiring medical attention).

Per Title 59 Illinois Administrative Code Part 116, a medication error shall be immediately reported to the registered professional nurse, advanced practice nurse, physician, physician assistant, dentist, podiatrist or certified optometrist to receive direction on actions to be taken. All medication errors shall be documented in the individual's clinical record and a medication error report shall be completed within eight hours or before the end of the shift in which the error was discovered, whichever is earlier. A copy of the medication error report shall be maintained as part of the agency's quality assurance program.

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

In addition, the OA annually conducts on-site reviews of a representative sample of waiver participants annually. The OA team includes Registered Nurses. The team reviews participant medication regimen, medication administration, and compliance with rules applicable to medication management and administration.

The OA monitors for the following: written policies and procedures on reviewing adverse drug reactions; written policies and procedures on the review of medication errors; whether a medication error report is made for every medication error noted on the MAR; whether a review of medication administration is conducted by the nurse-trainer on a quarterly basis and that medication labels and MARs match the physician order sheets; and whether medications are being administered as prescribed and whether refusals are documented properly; and whether medication errors are reviewed by the nurse-trainer within 7 days of each occurrence.

When findings are discovered, the provider is required to develop a corrective action plan subject to the approval of the OA. The remediation must address the individual finding(s) as well as any other similar practices involving other individuals served by the provider. The provider must develop a quality assurance process to prevent future occurrences.

If serious findings are discovered, an immediate corrective action can be required (meaning remediation must occur before the OA reviewer exits the provider) or within a short time frame no more than 48 hours of the completion of the review. Plans to safeguard the welfare of participants until corrective action is implemented can include increased monitoring visits, or moving waiver participants either temporarily or permanently to other settings.

OA findings are summarized and reported to the Waiver Quality Management Committee (QMC) which includes key staff from the OA and MA. The Waiver QMC meets quarterly and develops appropriate system improvements in response to identified trends and concerns. The QMC meeting summary is a record of

system improvements and outcomes.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **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)*

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).

When medications are provided or employees of a waiver Residential Habilitation 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 Habilitation 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). Developmental Training providers may not allow non-licensed direct support persons to administer medications.

When providers 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 participants with developmental disabilities.

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 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.

The 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 medications, 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.

Administrative Rule 116 permits a registered nurse who has successfully completed the Operating Agency/DHS-approved nurse-trainer course for medication administration in the community (5 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 8 hours of classroom training on medication administration. In addition, competency-based training is required specific to the participant, the medication and the dosages. 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 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.

An individual Medication Administration Record (MAR) must be kept for each participant for medication administered. It must contain at least the following:
1) the participant's name;
2) the name and dosage form of the drug;
3) the name of the prescribing physician, physician assistant, advanced practice nurse, dentist, podiatrist, or certified optometrist;
4) dose;
5) frequency or times of administration;
6) route of administration;
7) date and time given;
8) most recent date of the order;
9) allergies to medication; and
10) special considerations.

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.

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:

The OA

(b) Specify the types of medication errors that providers are required to *record:*

Waiver Residential Habilitation providers are required to record all medication errors.

(c) Specify the types of medication errors that providers must *report* to the State:

Any medication error that results in an adverse outcome is reported to the OA within seven calendar 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.

Residential providers subject to medication administration requirements are monitored by the OA for compliance. Providers are required to track all medication errors and to report to the OA all errors with an adverse outcome (defined as requiring medical attention).

The OA reviews a representative sample of waiver participants annually. The OA team includes Registered Nurses. The team reviews participant medication regimen, medication administration, and compliance with rules applicable to medication management and administration.

The OA monitors for the following: written policies and procedures on reviewing adverse drug reactions; written policies and procedures on the review of medication errors; whether a medication error report is made for every medication error noted on the MAR; whether a review of medication administration is conducted by the nurse-trainer on a quarterly basis and that labels match the physician order sheets; and whether medications are being administered as prescribed and whether refusals are documented properly; and whether medication errors are reviewed by the nurse-trainer with 7 days of each occurrence.

A medication error shall be immediately reported to the registered professional nurse, advanced practice nurse, physician, physician assistant, dentist, podiatrist or certified optometrist to receive direction on actions to be taken. All medication errors shall be documented in the individual's clinical record and a medication error report shall be completed within eight hours or before the end of the shift in which the error was discovered, whichever is earlier. A copy of the medication error report shall be maintained as part of the agency's quality assurance program.

Any medication error that results in an adverse outcome is reported to the OA within seven calendar days. All reports are reviewed by the OA and followed up as necessary to ensure that adequate safeguards are in place to prevent future occurrences.

When findings are discovered, the provider is required to develop a corrective action plan subject to the approval of the OA. The remediation must address the individual finding(s) as well as any other similar practices involving other individuals served by the provider. The provider must develop a quality assurance process to prevent future occurrences.

If serious findings are discovered, an immediate corrective action can be required (meaning remediation must occur before the OA reviewer exits the provider) or within a short time frame no more than 48 hours of the completion of the review. Plans to safeguard the welfare of participants until corrective action is implemented can include increased monitoring visits, or moving waiver participants either temporarily or permanently to other settings.

OA findings are summarized and reported to the Waiver Quality Management Committee (QMC) which includes key staff from the OA and MA. The Waiver QMC meets quarterly and develops appropriate system improvements in response to identified trends and concerns. The QMC meeting summary is a record of system improvements and outcomes.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis,*

identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
32G The number and percent of participant records reviewed that documented the participant (and/or guardian) received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved waiver. N: Number of records where participant received information on how to report abuse/neglect. D: Number of participants in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
33G Number and percent of participants reviewed for whom critical incidents were identified and appropriate measures taken by the provider. N: Number of participants reviewed with at least one critical incident reported where the provider took appropriate measures. D: Number of participants identified in the sample with at least one critical incident.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☑ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Within the representative sample, participants with at least one incident
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
34G Number and percent of participants reviewed who received the coordination and support to access health care services identified in their service plan. N: Number of participants reviewed who received support to access healthcare services. D: Number of participants in the sample with health care services identified in their ISP.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Within the representative sample, those with health care needs identified in the ISP
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

35G The number and percent of reportable deaths that were reported within the required timelines. N: Number of reportable deaths reported within required timelines. D: All reportable deaths.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA (DHS) Office of Inspector General (OIG) and Medicaid eligibility file.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**

	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
36G The number and percent of participants reviewed with identified restrictive interventions where procedures were followed as specified in the approved waiver. N: Number of restrictive interventions that followed required procedures. D: Number of participants identified in the sample with at least one restrictive intervention.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Within the representative sample, those with at least one restrictive intervention
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
37G In response to OIG substantiated abuse, neglect or financial exploitation investigations, the number and percent of written responses received from the provider and approved by the OA within 60 calendar days of completion of OIG investigation report. N: Number of written responses approved by the OA within required time frames. D: Total number of substantiated investigations.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Medicaid Agency (MA) conducts select reviews as part of MA oversight and quality assurance.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
32G, 33G, 34G, 36G: (same as 21D) The OA is responsible for individual remediation. A POC is submitted by the provider to the OA for approval within 14 days of notification to provider of findings. The POC must correct the findings within 60 calendar days. In instances of serious findings the provider may be directed by the OA to correct a finding in a much shorter time frame, including instances of immediate correction, where appropriate. In instances where the provider fails to submit a plan or when the provider fails to submit an acceptable plan, the OA may develop and impose a mandatory POC.

35G: The OA is responsible for individual remediation of provider failure to report deaths subject to required reporting. Upon discovery, the death is reported to the OA Office of Inspector General (OIG) within the required time frame. Depending on the specific circumstances identified, a POC may be required. See above for description of OA Plan of Correction (POC) process.

37G: The OA is responsible for reviewing and approving written responses from providers. A written response is submitted by the provider to the OA for approval within 60 calendar days of completion of the OIG investigation report. In instances where the provider fails to submit a written response within the required time frame and/or when the provider fails to submit an acceptable WR, the OA imposes a mandatory corrective action plan.

The OA may impose sanctions on providers which fails to comply with conditions stipulated in the provider contract. Sanctions include, but are not limited to, payment suspension, loss of payment, and enrollment limitations, or other actions up to and including contract termination.

The OA provides quarterly reports of findings and remediation activities to the MA. Staff of the MA and OA review the reports on a quarterly basis as part of the Waiver Quality Management Committee (QMC) meetings. The QMC meeting summaries document the actions taken.

ii. Remediation Data Aggregation
Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that*	**Frequency of data aggregation and**

applies):	**analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

○ **No**
◉ **Yes**
Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
The State has developed a Corrective Action Plan that is being incorporated into the waiver by reference. The OA is responsible for implementing the Plan. The MA will receive and review draft results from each step with sufficient time for comment before the due date.

Appendix H: Quality Improvement Strategy (1 of 2)

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 Improvement 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.

CMS recognizes that a state's waiver Quality Improvement 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 Improvement 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 Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement 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 Improvement Strategy, including the specific tasks the State plans to undertake during the period 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 Improvement 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/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The OA currently receives and maintains data from the Abuse/Neglect/Exploitation database and the Complaint database. As the new Critical Incident Reporting System is developed, the OA will also receive and maintain data from that database as well. (Please see Action Plan.) Data from these three sources will be combined using common data fields. Summary information and trend analysis is discussed during quarterly Quality Management Committee meetings of the MA and OA staff. Necessary remediation will be identified and documented on the System Improvement Log.

The Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency (MA), and the Illinois Department of Human Services, Division of Developmental Disabilities, as the Operating Agency (OA), work in partnership to evaluate the waiver Quality Management System (QMS) and to analyze the information derived from discovery and remediation activities for each of the assurances.

The OA is responsible for almost all of the data collection to address the Quality Management System discovery and remediation sections located the Appendices. The State's system improvement activities are in response to aggregated and analyzed discovery and remediation data collected on each of the assurances.

The sources of discovery evidence vary, but all are based on either a 100 % or the representative sampling methodology as indicated for each performance measure. The OA annually selects a representative sample of waiver participants. Onsite reviews are scheduled and conducted throughout the year at Independent Service Coordination and direct service providers. Data is collected throughout the year and individual problems are remediated as they are identified. The MA participates in select reviews with the OA team as part of MA

oversight and quality assurance. Other data sources include the State information system and other reports as indicated in the waiver.

The Adults with Developmental Disabilities waiver Quality Management System (QMS) plan is part of an overall quality management plan for the three 1915 (c) waivers operated by the DHS, Division of Developmental Disabilities (OA). The other waivers include the Children's Support Waiver (control number IL.0464.R01.01), and the Children's Residential Waiver (control number IL.0473.R01.01). While some data may be collected during the same on-site provider reviews, the sample for each waiver is drawn separately and the results aggregated separately.

The OA conducts a Quality Management Committee (QMC) meeting with the MA each quarter to review data collected from the previous quarter and for the year to date. Data to be collected semi-annually or annually are reported as indicated by the performance measure in the waiver. All reports are provided to MA for review prior to the quarterly meetings. Annual reports are produced identifying trends based on the full representative sample and/or 100% review of data.

The OA reports on all data collected for the three developmental disabilities waivers, however data is reported separately, by waiver. Data is reported by individual performance measure and in total for comparison to all performance measures. Individual performance measure reports include timeliness of remediation based on immediate, 30, 60, 90 day increments and remediation outstanding.

The MA and OA identify trends based on scope, severity, changes and patterns of compliance. Identified trends are discussed and analyzed regarding cause, contributing factors and opportunities for system improvement. Suggestions for system changes are added to the OA's Waiver QMC System Improvement Log for tracking purposes. Decisions and timelines regarding system improvement are made based on consensus of priority and specific steps needed to accomplish change. To assist in the development and evaluation of system improvement strategies, the State seeks input from stakeholders. The OA Quality Committee made up of participants and family members, providers, advocates and other interested parties meets to provide advise to the OA about proposed system design changes. The MA is a member of the Quality Committee.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The processes Illinois follows to continuously evaluate, as appropriate, effectiveness of the QMS are the same as the processes to evaluate the information derived from discovery and remediation activities. The Waiver Quality Management Committee (QMC) System Improvement Log is a dynamic product that is discussed quarterly by key staff of the MA and the OA regarding progress, updates and evaluation of effectiveness. Effectiveness is measured by impact on performance based on ongoing data collection over time, feedback

from participant/guardian interviews, surveys, and service providers. Multiple years of data collection will allow the State to evaluate the effectiveness of system improvements over time. One meeting of the Waiver QMC each year is partly devoted to an overview of the previous year's activities and a discussion of whether changes are needed to the Quality Management Strategy. System design changes may be specific to one waiver or may involve multiple waivers.

The State provides information about the results of system improvement activities to stakeholders, including participants and guardians, family members, waiver service providers, advocates and other interested parties by developing summary reports, program Information Bulletins and/or waiver manual updates. Information is continually posted on the OA website. Providers and advocacy organizations are informed via electronic mail as Information Bulletins, manual updates and training curriculum modifications are made available. Private individuals can submit their email addresses on line to the OA and be added to the list serve to receive electronic information as well. When indicated, the OA also conducts informational webinars regarding policy and procedure changes.

Quarterly, the OA posts a summary report of the results of the waiver performance measures on its website.

The Operating Agency (OA) posts on its website information on each agency regarding licensure and quality assurance survey results; licensure and contract status; and substantiated findings of abuse, egregious neglect, and exploitation.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Each year one meeting of the Waiver QMC is partly devoted to an overview of the previous year's activities and a discussion of whether changes are needed to the overall Quality Improvement Strategy. At the meeting, the MA and OA discuss whether to make changes in existing performance measures, add measures or discontinue measures. The State continually strives to increase the compliance rate of each performance. While the target compliance rate for each performance measure is 100%, the State realizes that it may take multiple system changes over several years to reach the goal of 100% compliance.

Appendix I: Financial Accountability

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.

The 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.

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 performs desk reviews and on-site reviews of a sample of the independent audits on an annual basis.

The Medicaid and Operating Agencies work cooperatively to review rates and provider claims. The MA delegates to

the OA the financial oversight of claims.

The OA reivews either a representative sample or 100% of claims verifying the following:

1) The individual was eligible and enrolled in the waiver on the date of service, and,

2) Claiming rates were in accordance with the reimbursement methodology.

In addition, the OA selects a representative sample of claims and conducts post payment reviews to verify whether the services were approved in the participant's service plan.

The OA summarizes the post payment review data and provides quarterly reports to the MA of their findings and all remediation activities. Remediation may include, technical assistance to providers, adjusting or voiding claims, modify and strengthen internal controls, conducting focused reviews, or requiring plans of correction from providers, as appropriate.

The MA performs a validation review based on the OA report to verify that post payment review procedures were followed and appropriate remediation actions taken.

The MA's validation review includes an assessment and review of the internal controls established by the OA. The MA assesses the appropriateness of established controls and performs tests to provide reasonable assurance that the established controls are followed. The MA uses the data warehouse to verify that claiming errors were corrected by crediting CMS with any applicable FFP. As a result of validation reviews, the MA works with the OA to modify and strengthen internal controls as needed.

The OA reviews rate calculations anytime there is a significant change in the computerized management information system.

The results of all financial reviews are shared between the two State agencies and discussed during the Waiver Quality Management Committee (QMC) meetings. In addition, results of some reviews may be shared with the Statewide Advisory Council on Developmental Disabilities and other ad hoc groups in order to obtain input from stakeholders regarding findings and corrective actions.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
    i. **Sub-Assurances:**
        a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on

the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
38I Number and percent of waiver claims reviewed that were submitted using the correct rate as specified in the waiver application. N: Number of claims with correct rate. D: All claims in representative sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Comparison of claims with approved rates

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☑ **Annually**

Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
39I Number and percent of waiver service claims that were submitted for participants who were Medicaid waiver eligible on the date that the service was delivered. N: Number of claims submitted for participants who were Medicaid eligible on the date the service was provided. D: All claims.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA MIS automated reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
40I Number and percent of reviewed waiver service claims submitted for FFP that are specified in the participant's service plan. N: Number of claims reviewed that were specified in the ISP. D: Number of claims sampled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Comparison of claims with service plans in sample

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Medicaid Agency (MA) conducts select reviews as part of MA oversight and quality assurance.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The OA is responsible for seeing that individual issues are resolved.

38I: Upon discovery, the OA analyzes claims processing logic to identify errors and correct claim rate errors on both an individual and systemic level (to prevent repeat errors).

39I: Upon discovery, determination of waiver eligibility and if participant is eligible, no further action. If participant is ineligible, adjust claim.

40I: Upon discovery, if the provider is no longer providing services or the participant is no longer receiving services, no further action is taken. If the participant is still actively receiving services, request a copy of the current ISP to determine if the need for the service is addressed. If the services are needed and addressed in the current ISP, no further action is taken. If the services are needed and not included in the current ISP, require an updated ISP from the provider. If the service is not needed by the participant, terminate the service.

The OA may impose sanctions on providers which fails to comply with conditions stipulated in the provider contract. Sanctions include, but are not limited to, payment suspension, loss of payment, and enrollment limitations, or other actions up to and including contract termination.

The OA provides summary reports of remediation activities to the MA. Staff of the MA and OA review the reports on a quarterly basis as part of the Waiver Quality Management Committee (QMC) meetings. QMC meeting summaries document the actions taken.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

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 Illinois Department on Aging in their Waiver program for elderly persons, 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 (CLF) and some CILA rates from legacy programs are calculated based on past individual provider cost reports. Rates are 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 Developmental Training (DT) average allowable costs. The rate is 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 (Individual and Group)
The statewide standard claiming rates are based on the historical statewide DT rate with incentives to encourage Supported Employment (SEP) programs generally and Supported Employment in individual job settings specifically. Rates are established for individual and group SEP services. The rates are subject to cost of living adjustments when enacted.

Personal Support/Temporary Assistance Services
Rates for Personal Support and Temporary Assistance are negotiated between the participant, guardian (as applicable) or representatives and the providers with assistance from the Service Facilitator. The negotiated rates are specified in the Service Agreement 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.

Home and Vehicle Modifications, Adaptive Equipment (including Assistive Technology)
Rates are usual and customary. Payments are subject to prior approval by the Operating Agency. Two bids are required for approval. Per-participant five-year cost limits and specific cost limits on rental housing governing the use of these services.

Non-medical Transportation
Statewide mileage rates are set by the Operating Agency. Per-trip rates are usual and customary charges. The rate is subject to cost of living adjustments when enacted by the General Assembly and signed by the Governor.

Emergency Home Response Services
The 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 for unpaid care givers is identical to the standard statewide rate currently used in the waiver for participants receiving Individual Counseling services. The rate is based on available cost data for licensed social workers on contract with traditional developmental disabilities agencies. The rate is subject to cost of living adjustments when enacted. Reimbursement for training for unpaid care givers is based on usual and customary charges for the tuition or fees to attend the program. Transportation, meals and lodging to attend training are not included. Reimbursement for training for unpaid care givers is 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 (Level I) 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 (Level II) 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 Skilled Nursing
These rates are based on available cost data for clinical psychologists, social workers and nurses on contract with traditional developmental disabilities agencies. The 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 Individual Service and Support Advocacy (ISSA) rate are identical because both services are provided by QIDP (QMRP) staff. The rate is a standard statewide hourly rate. The rate is subject to cost of living adjustments when enacted.

24-Hour Stabilization Services
The rates for this service are initially established through a Request for Applications process. Through this process, the State compares the proposed rates of willing providers. A standard methodology is developed for the waiver service with variation based upon a number of factors defined below. The required components that are used to establish the rate are:

• Direct support staff wages;
• Professional staff wages and clinical contracts, e.g., QIDPs, Behavior Analysts, nurses, etc.;
• Employment-related expenditures, e.g., employee benefits, FICA, unemployment insurance, workers' compensation, etc.;
• Program-related expenditures, e.g., supervision, supplies, etc.;
• Utilization factors;
• Administration, e.g., administrative salaries, staff travel, office space and expenses; and
• Transportation of individuals.

The following additional factors may influence the standard methodology and are the basis for rate variations. When all factors are equal, the rates produced by the standard methodology would be the same.
• Provider rates may vary due to geographic differences.
• A differential may be included in the rate for the level of expertise and skill of specific professional staff; the differential will again be uniform across all providers.

Once the rates are established, rates may be adjusted through contractual amendments subject to cost of living increases appropriated by the Illinois General Assembly, through negotiations during contract renewals, or through subsequent calls for Request for Applications.

Established rates are published on the Operating Agency's website at: http://www.dhs.state.il.us/page.aspx?item=38992. The rates published for 24-Hour Stabilization services are actual rates for services.

RFAs are posted on a website used by all State agencies to list contracting opportunities with the State. This website is referred to as the Illinois Procurement Bulletin (IPB). Vendors of all types can register on the IPB to do business with the state, to review requests for information or proposals, and receive updates on procurement rules and requirements. The RFA for this service used the IPB website. We believe this process is an effective means to identify all qualified and willing providers and to compare their costs.

The State anticipates there may be geographic differences in the wages of direct support staff, as well as those of professional staff. We believe there may also be geographic differences in the pricing of clinical contracts such as those with behavior therapists, nurses, etc. There may also be differences in administrative components, employment related costs, and transportation expenses. We also anticipate differences in room and board components; however, those components will not be included in the claiming rate submitted for Medicaid match. We anticipate one vendor will be operating in the Cook County area near Chicago; the other vendor would be operating in Central Illinois in a relatively more rural area.

The Illinois General Assembly reviews funding allocations on an annual basis. We cannot predict, however, how

frequently the Administration and General Assembly may consider COLAs for various services.

The MA retains and exercises final authority over payment rates. It does so in collaboration with the OA, which develops the proposed rates and shares the proposed rates and methodology with HFS for its approval.

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 participants and guardian (when applicable), family members, waiver case managers/Service Facilitators, ISSA and providers. Copies of rate methodologies are on file with the Medicaid Agency and the Operating Agency.

b. 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 (OA). 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 where the participant exercises employer authority, flow through the Financial Management Service (FMS) entity and are paid and transmitted to the Operating Agency (DHS) system for claims processing.

Operating Agency Claims Processing
Information from the Operating Agency computerized payment system 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 a weekly 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. A small portion of the federal matching funds is deposited into a dedicated fund to be used to fund community services for individuals with developmental disabilities.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government 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 Local Government Agencies.**

Specify: (a) the local government 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.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

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 (OA) to verify the effective date of each Waiver service authorized in the participant's service plan and the participant's level of care eligibility. Providers are required to certify billings are true and accurate.

Provider claims are further validated by applying MMIS processing edits and by conducting Operating Agency (DHS) post-payment reviews. See also Appendix I-1 for additional information on post-payment reviews. Through post-payment reviews, the Operating Agency, based on a representative sample of claims, confirms that services were in accordance with the service 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 §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

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) and 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:

- ◉ **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 weekly basis, Waiver claims are edited and sent to the Medicaid Agency for Medicaid claiming. The audit trail is established through State agency approved rates, service plan authorization, documentation of service delivery, and computerized payment and claiming systems cross-matched with the Medicaid Agency, MMIS system.

The OA performs a post payment review, based on a representative sample of waiver claims. The post payment review looks at whether the services were specified in the service plan. The OA reviews a representative sample of claims to determine whether the individual was eligible on the date of services. The OA reviews a representative sample of waiver claims to determine whether the rates paid are in accordance with the reimbursement methodology. The OA submits a quarterly report to the MA with their findings and remediation activities. The MA conducts a validation review based on the quarterly reports to verify that the OA followed their post payment review procedures and verifies that appropriate remediation actions were taken.

- ○ **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:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **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 (FMS) entity, as described in Appendix E, makes payments directly to providers of Waiver services. The Operating Agency then sends electronic claims via computer tape based on the paid services 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.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

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 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; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. 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.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

◉ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

○ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ○ **The amount paid to State or local government 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 State or local government providers differs from the amount paid to private providers of the same service. When a State or local government 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:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

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 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.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ○ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ◉ **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 (OA)

ii. Organized Health Care Delivery System. *Select one:*

- ◉ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ○ **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:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- ◉ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ○ **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.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

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. *Select at least one*:

☐ **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 State 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 State agencies as CPEs, as indicated in Item I-2-c:

Funds are directly appropriated by the Illinois General Assembly from the General Revenue Funds to the OA (DHS). A portion of the funds are deposited into a dedicated fund for services to persons with developmental disabilities. The funds are not transferred.

☐ **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 State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government 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. *Select One*:

◉ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.

○ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government 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 local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government 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 local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

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: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

  Check each that applies:
  - [ ] **Health care-related taxes or fees**
  - [ ] **Provider-related donations**
  - [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

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 individualized rates for a participant in a Residential Habilitation setting based on a rate 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 determines waiver claims for Residential Habiliation services based on the Program, Transportation, Administration and Individual Supports components of the rates. The Room and Board Component is excluded when calculating Waiver claims.

Appendix I: Financial Accountability

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:*

- (●) **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.

- ○ **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:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. 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.**
- ○ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

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:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *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; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: ICF/IID

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 (Col 7 less Column4)
1	30432.00	3553.99	33985.99	84537.46	3561.40	88098.86	54112.87

2	31434.00	3707.07	35141.07	84809.36	3580.24	88389.60	53248.53
3	31434.00	3866.75	35300.75	85082.13	3599.18	88681.31	53380.56
4	31295.00	4033.30	35328.30	85355.78	3618.21	88973.99	53645.69
5	31295.00	4207.03	35502.03	85630.30	3637.35	89267.65	53765.62

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

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:
		ICF/IID
Year 1	**19000**	19000
Year 2	**19000**	19000
Year 3	**19000**	19000
Year 4	**20840**	20840
Year 5	**20840**	20840

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

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-a.

The average length of stay is estimated based on the actual length of stay for current waiver participants for State Fiscal Years 2013 through 2017.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

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 FY2010 and FY2011 year-to-date actual Waiver enrollment and service utilization patterns and costs for each Waiver service. Operating Agency staff analyzed data from the 372 report for FY2010 and a database that contains information on paid Waiver services. The database includes the number of users for each service and the number of units of each service received.

Cost estimates are based on current FY12 claiming rates (Waiver Year 5). There are no budgeted rate

increases in FY13 (Waiver Year 1). 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:

Ancillary service data was pulled for those people with a DD waiver provider for WY'08 - WY'12. Factor D Prime cost per capita is estimated to increase by 4.31% for WY'13 - WY'17. This percentage is based upon the average historical percent change for WY'08 - WY'12 actual ancillary expenditures for Adults with Developmentally Disabled Waiver participants and carried forward to WY'13 - WY'17. Ancillary cost data were adjusted to exclude prescription medicines now covered by Medicare Part D.

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 2008 - 2012. Factor G estimated for WY2013 - FY2017 is based on the historical percent changes trended forward for all years. The average historical cost per capita increase was 0.53%.

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 ICF/MR setting for FY2008 - FY2012. Factor G’ estimated for FY2008 to FY2012 is based upon historical percent changes trended forward for all years. The average historical cost per capita increase was 0.32%.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services
Adult Day Care
Developmental Training
Residential Habilitation
Supported Employment - Individual and Group
Occupational Therapy (Extended Medicaid State Plan)
Physical Therapy (Extended Medicaid State Plan)
Speech Therapy (Extended Medicaid State Plan)
Service Facilitation
24-Hour Stabilization Services
Adaptive Equipment
Behavior Intervention and Treatment
Behavioral Services (Psychotherapy and Counseling)
Emergency Home Response Services (EHRS)
Home Accessibility Modifications
Non-Medical Transportation
Personal Support
Skilled Nursing
Temporary Assistance (formerly called Crisis Services)
Training and Counseling Services for Unpaid Caregivers
Vehicle Modification

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**192000.00**
Adult Day Care	Hour	20	800.00	12.00	**192000.00**	
Developmental Training Total:						**152449200.00**
Developmental Training	Hour	15300	940.00	10.60	**152449200.00**	
Residential Habilitation Total:						**353298000.00**
Residential Habilitation	Day	10600	330.00	101.00	**353298000.00**	
Supported Employment - Individual and Group Total:						**8050000.00**
Supported Employment-Individual	Hour	900	500.00	13.00	**5850000.00**	
Supported Employment-Group	Hour	400	500.00	11.00	**2200000.00**	
Occupational Therapy (Extended Medicaid State Plan) Total:						**177600.00**
Occupational Therapy (Extended Medicaid State Plan)	Hour	300	16.00	37.00	**177600.00**	
Physical Therapy (Extended Medicaid State Plan) Total:						**83250.00**
Physical Therapy (Extended Medicaid State Plan)	Hour	150	15.00	37.00	**83250.00**	
Speech Therapy (Extended Medicaid State Plan) Total:						**29600.00**
Speech Therapy (Extended Medicaid State Plan)	Hour	200	4.00	37.00	**29600.00**	
Service Facilitation Total:						**5160000.00**
Service Facilitation	Hour	4300	30.00	40.00	**5160000.00**	
24-Hour Stabilization Services Total:						**0.00**
24-Hour Stabilization Services	Day	0	0.00	0.01	**0.00**	
Adaptive Equipment Total:						**12500.00**
Adaptive Equipment					**12500.00**	

	Per Item	25	1.00	500.00		
Behavior Intervention and Treatment Total:						**5980000.00**
Behavior Intervention and Treatment	Hour	4600	20.00	65.00	**5980000.00**	
Behavioral Services (Psychotherapy and Counseling) Total:						**968600.00**
Behavioral Services-Psychotherapy-Individual	Hour	1000	17.00	37.00	**629000.00**	
Behavioral Services-Psychotherapy-Group	Hour	400	17.00	12.00	**81600.00**	
Behavioral Services-Counseling-Individual	Hour	600	12.00	30.00	**216000.00**	
Behavioral Services-Counseling-Group	Hour	350	12.00	10.00	**42000.00**	
Emergency Home Response Services (EHRS) Total:						**3000.00**
Emergency Home Response Services (EHRS)	Per Month (1 X insta	10	10.00	30.00	**3000.00**	
Home Accessibility Modifications Total:						**780000.00**
Home Accessibility Modifications	Per Item	100	1.00	7800.00	**780000.00**	
Non-Medical Transportation Total:						**288000.00**
Non-Medical Transportation	Per Item	200	120.00	12.00	**288000.00**	
Personal Support Total:						**50400000.00**
Personal Support	Hour	4000	900.00	14.00	**50400000.00**	
Skilled Nursing Total:						**20150.00**
Skilled Nursing	Hour	10	65.00	31.00	**20150.00**	
Temporary Assistance (formerly called Crisis Services) Total:						**79200.00**
Temporary Assistance (formerly called Crisis Services)	Hour	20	360.00	11.00	**79200.00**	
Training and Counseling Services for Unpaid Caregivers Total:						**12500.00**
Counseling Services for Unpaid Caregivers	Hour	25	10.00	30.00	**7500.00**	
Training Services for Unpaid Caregivers	Per Event	25	1.00	200.00	**5000.00**	
Vehicle Modification Total:						**225000.00**
Vehicle Modification	Per Item	25	1.00	9000.00	**225000.00**	

GRAND TOTAL:	**578208600.00**
Total Estimated Unduplicated Participants:	**19000**
Factor D (Divide total by number of participants):	**30432.00**
Average Length of Stay on the Waiver:	335

Appendix J: Cost Neutrality Demonstration

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**192000.00**
Adult Day Care	Hour	20	800.00	12.00	**192000.00**	
Developmental Training Total:						**152449200.00**
Developmental Training	Hour	15300	940.00	10.60	**152449200.00**	
Residential Habilitation Total:						**367290000.00**
Residential Habilitation	Day	10600	330.00	105.00	**367290000.00**	
Supported Employment - Individual and Group Total:						**8050000.00**
Supported Employment-Individual	Hour	900	500.00	13.00	**5850000.00**	
Supported Employment-Group	Hour	400	500.00	11.00	**2200000.00**	
Occupational Therapy (Extended Medicaid State Plan) Total:						**177600.00**
Occupational Therapy (Extended Medicaid State Plan)	Hour	300	16.00	37.00	**177600.00**	
Physical Therapy (Extended Medicaid State Plan) Total:						**83250.00**
Physical Therapy (Extended Medicaid State Plan)	Hour	150	15.00	37.00	**83250.00**	
Speech Therapy (Extended Medicaid State Plan) Total:						**29600.00**
Speech Therapy (Extended Medicaid State Plan)	Hour	200	4.00	37.00	**29600.00**	
Service Facilitation Total:						**5388760.00**
Service Facilitation	Hour	4300	31.33	40.00	**5388760.00**	
24-Hour Stabilization Services Total:						**0.00**
24-Hour Stabilization Services	Day	0	0.00	0.01	**0.00**	
Adaptive Equipment Total:						**12500.00**
Adaptive Equipment	Per Item	25	1.00	500.00	**12500.00**	
Behavior Intervention and Treatment Total:						**9037022.00**

Behavior Intervention and Treatment	Hour	4600	27.67	71.00	**9037022.00**	
Behavioral Services (Psychotherapy and Counseling) Total:						**968600.00**
Behavioral Services-Psychotherapy-Individual	Hour	1000	17.00	37.00	**629000.00**	
Behavioral Services-Psychotherapy-Group	Hour	400	17.00	12.00	**81600.00**	
Behavioral Services-Counseling-Individual	Hour	600	12.00	30.00	**216000.00**	
Behavioral Services-Counseling-Group	Hour	350	12.00	10.00	**42000.00**	
Emergency Home Response Services (EHRS) Total:						**3000.00**
Emergency Home Response Services (EHRS)	Per Month (1 X insta	10	10.00	30.00	**3000.00**	
Home Accessibility Modifications Total:						**780000.00**
Home Accessibility Modifications	Per Item	100	1.00	7800.00	**780000.00**	
Non-Medical Transportation Total:						**288000.00**
Non-Medical Transportation	Per Item	200	120.00	12.00	**288000.00**	
Personal Support Total:						**52155000.00**
Personal Support	Hour	4000	915.00	14.25	**52155000.00**	
Skilled Nursing Total:						**20150.00**
Skilled Nursing	Hour	10	65.00	31.00	**20150.00**	
Temporary Assistance (formerly called Crisis Services) Total:						**79200.00**
Temporary Assistance (formerly called Crisis Services)	Hour	20	360.00	11.00	**79200.00**	
Training and Counseling Services for Unpaid Caregivers Total:						**12500.00**
Counseling Services for Unpaid Caregivers	Per Event	25	10.00	30.00	**7500.00**	
Training Services for Unpaid Caregivers	Per Event	25	1.00	200.00	**5000.00**	
Vehicle Modification Total:						**225000.00**
Vehicle Modification	Per Item	25	1.00	9000.00	**225000.00**	
				GRAND TOTAL:		**597241382.00**
				Total Estimated Unduplicated Participants:		**19000**
				Factor D (Divide total by number of participants):		**31434.00**
				Average Length of Stay on the Waiver:		335

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**192000.00**
Adult Day Care	Hour	20	800.00	12.00	**192000.00**	
Developmental Training Total:						**152449200.00**
Developmental Training	Hour	15300	940.00	10.60	**152449200.00**	
Residential Habilitation Total:						**367290000.00**
Residential Habilitation	Day	10600	330.00	105.00	**367290000.00**	
Supported Employment - Individual and Group Total:						**8050000.00**
Supported Employment-Individual	Hour	900	500.00	13.00	**5850000.00**	
Supported Employment-Group	Hour	400	500.00	11.00	**2200000.00**	
Occupational Therapy (Extended Medicaid State Plan) Total:						**177600.00**
Occupational Therapy (Extended Medicaid State Plan)	Hour	300	16.00	37.00	**177600.00**	
Physical Therapy (Extended Medicaid State Plan) Total:						**83250.00**
Physical Therapy (Extended Medicaid State Plan)	Hour	150	15.00	37.00	**83250.00**	
Speech Therapy (Extended Medicaid State Plan) Total:						**29600.00**
Speech Therapy (Extended Medicaid State Plan)	Hour	200	4.00	37.00	**29600.00**	
Service Facilitation Total:						**5388760.00**
Service Facilitation	Hour	4300	31.33	40.00	**5388760.00**	
24-Hour Stabilization Services Total:						**0.00**
24-Hour Stabilization Services	Day	0	0.00	0.01	**0.00**	
Adaptive Equipment Total:						**12500.00**
Adaptive Equipment	Per Item	25	1.00	500.00	**12500.00**	
Behavior Intervention and Treatment Total:						**9037022.00**
Behavior Intervention and Treatment	Hour	4600	27.67	71.00	**9037022.00**	
Behavioral Services (Psychotherapy and						**968600.00**

Counseling) Total:						
Behavioral Services-Psychotherapy-Individual	Hour	1000	17.00	37.00	**629000.00**	
Behavioral Services-Psychotherapy-Group	Hour	400	17.00	12.00	**81600.00**	
Behavioral Services-Counseling-Individual	Hour	600	12.00	30.00	**216000.00**	
Behavioral Services-Counseling-Group	Hour	350	12.00	10.00	**42000.00**	
Emergency Home Response Services (EHRS) Total:						**3000.00**
Emergency Home Response Services (EHRS)	Per Month (1 X insta	10	10.00	30.00	**3000.00**	
Home Accessibility Modifications Total:						**780000.00**
Home Accessibility Modifications	Per Item	100	1.00	7800.00	**780000.00**	
Non-Medical Transportation Total:						**288000.00**
Non-Medical Transportation	Per Item	200	120.00	12.00	**288000.00**	
Personal Support Total:						**52155000.00**
Personal Support	Hour	4000	915.00	14.25	**52155000.00**	
Skilled Nursing Total:						**20150.00**
Skilled Nursing	Hour	10	65.00	31.00	**20150.00**	
Temporary Assistance (formerly called Crisis Services) Total:						**79200.00**
Temporary Assistance (formerly called Crisis Services)	Hour	20	360.00	11.00	**79200.00**	
Training and Counseling Services for Unpaid Caregivers Total:						**12500.00**
Counseling Services for Unpaid Caregivers	Per Event	25	10.00	30.00	**7500.00**	
Training Services for Unpaid Caregivers	Per Event	25	1.00	200.00	**5000.00**	
Vehicle Modification Total:						**225000.00**
Vehicle Modification	Per Item	25	1.00	9000.00	**225000.00**	
				GRAND TOTAL:		**597241382.00**
				Total Estimated Unduplicated Participants:		**19000**
				Factor D (Divide total by number of participants):		**31434.00**
				Average Length of Stay on the Waiver:		335

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to

automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**192000.00**
Adult Day Care	Hour	20	800.00	12.00	**192000.00**	
Developmental Training Total:						**156434800.00**
Developmental Training	Hour	15700	940.00	10.60	**156434800.00**	
Residential Habilitation Total:						**388080000.00**
Residential Habilitation	Day	11200	330.00	105.00	**388080000.00**	
Supported Employment - Individual and Group Total:						**9250000.00**
Supported Employment-Individual	Hour	1000	500.00	13.00	**6500000.00**	
Supported Employment-Group	Hour	500	500.00	11.00	**2750000.00**	
Occupational Therapy (Extended Medicaid State Plan) Total:						**177600.00**
Occupational Therapy (Extended Medicaid State Plan)	Hour	300	16.00	37.00	**177600.00**	
Physical Therapy (Extended Medicaid State Plan) Total:						**83250.00**
Physical Therapy (Extended Medicaid State Plan)	Hour	150	15.00	37.00	**83250.00**	
Speech Therapy (Extended Medicaid State Plan) Total:						**29600.00**
Speech Therapy (Extended Medicaid State Plan)	Hour	200	4.00	37.00	**29600.00**	
Service Facilitation Total:						**7644520.00**
Service Facilitation	Hour	6100	31.33	40.00	**7644520.00**	
24-Hour Stabilization Services Total:						**3396750.00**
24-Hour Stabilization Services	Day	175	30.00	647.00	**3396750.00**	
Adaptive Equipment Total:						**12500.00**
Adaptive Equipment	Per Item	25	1.00	500.00	**12500.00**	
Behavior Intervention and Treatment Total:						**9822850.00**
Behavior Intervention and Treatment	Hour	5000	27.67	71.00	**9822850.00**	
Behavioral Services (Psychotherapy and Counseling) Total:						**1339500.00**
Behavioral Services-					**943500.00**	

Psychotherapy-Individual	Hour	1500	17.00	37.00		
Behavioral Services-Psychotherapy-Group	Hour	500	17.00	12.00	**102000.00**	
Behavioral Services-Counseling-Individual	Hour	700	12.00	30.00	**252000.00**	
Behavioral Services-Counseling-Group	Hour	350	12.00	10.00	**42000.00**	
Emergency Home Response Services (EHRS) Total:						**3000.00**
Emergency Home Response Services (EHRS)	Per Month (1 X insta	10	10.00	30.00	**3000.00**	
Home Accessibility Modifications Total:						**780000.00**
Home Accessibility Modifications	Per Item	100	1.00	7800.00	**780000.00**	
Non-Medical Transportation Total:						**288000.00**
Non-Medical Transportation	Per Item	200	120.00	12.00	**288000.00**	
Personal Support Total:						**74320875.00**
Personal Support	Hour	5700	915.00	14.25	**74320875.00**	
Skilled Nursing Total:						**20150.00**
Skilled Nursing	Hour	10	65.00	31.00	**20150.00**	
Temporary Assistance (formerly called Crisis Services) Total:						**79200.00**
Temporary Assistance (formerly called Crisis Services)	Hour	20	360.00	11.00	**79200.00**	
Training and Counseling Services for Unpaid Caregivers Total:						**12500.00**
Counseling Services for Unpaid Caregivers	Per Event	25	10.00	30.00	**7500.00**	
Training Services for Unpaid Caregivers	Per Event	25	1.00	200.00	**5000.00**	
Vehicle Modification Total:						**225000.00**
Vehicle Modification	Per Item	25	1.00	9000.00	**225000.00**	
				GRAND TOTAL:		**652192095.00**
				Total Estimated Unduplicated Participants:		**20840**
				Factor D (Divide total by number of participants):		**31295.00**
				Average Length of Stay on the Waiver:		335

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						**192000.00**
Adult Day Care	Hour	20	800.00	12.00	**192000.00**	
Developmental Training Total:						**156434800.00**
Developmental Training	Hour	15700	940.00	10.60	**156434800.00**	
Residential Habilitation Total:						**388080000.00**
Residential Habilitation	Day	11200	330.00	105.00	**388080000.00**	
Supported Employment - Individual and Group Total:						**9250000.00**
Supported Employment-Individual	Hour	1000	500.00	13.00	**6500000.00**	
Supported Employment-Group	Hour	500	500.00	11.00	**2750000.00**	
Occupational Therapy (Extended Medicaid State Plan) Total:						**177600.00**
Occupational Therapy (Extended Medicaid State Plan)	Hour	300	16.00	37.00	**177600.00**	
Physical Therapy (Extended Medicaid State Plan) Total:						**83250.00**
Physical Therapy (Extended Medicaid State Plan)	Hour	150	15.00	37.00	**83250.00**	
Speech Therapy (Extended Medicaid State Plan) Total:						**29600.00**
Speech Therapy (Extended Medicaid State Plan)	Hour	200	4.00	37.00	**29600.00**	
Service Facilitation Total:						**7644520.00**
Service Facilitation	Hour	6100	31.33	40.00	**7644520.00**	
24-Hour Stabilization Services Total:						**3396750.00**
24-Hour Stabilization Services	Day	175	30.00	647.00	**3396750.00**	
Adaptive Equipment Total:						**12500.00**
Adaptive Equipment	Per Item	25	1.00	500.00	**12500.00**	
Behavior Intervention and Treatment Total:						**9822850.00**
Behavior Intervention and Treatment	Hour	5000	27.67	71.00	**9822850.00**	
Behavioral Services (Psychotherapy and Counseling) Total:						**1339500.00**
Behavioral Services-Psychotherapy-Individual	Hour	1500	17.00	37.00	**943500.00**	
Behavioral Services-Psychotherapy-Group	Hour	500	17.00	12.00	**102000.00**	

Behavioral Services-Counseling-Individual	Hour	700	12.00	30.00	**252000.00**	
Behavioral Services-Counseling-Group	Hour	350	12.00	10.00	**42000.00**	
Emergency Home Response Services (EHRS) Total:						**3000.00**
Emergency Home Response Services (EHRS)	Per Month (1 X insta	10	10.00	30.00	**3000.00**	
Home Accessibility Modifications Total:						**780000.00**
Home Accessibility Modifications	Per Item	100	1.00	7800.00	**780000.00**	
Non-Medical Transportation Total:						**288000.00**
Non-Medical Transportation	Per Item	200	120.00	12.00	**288000.00**	
Personal Support Total:						**74320875.00**
Personal Support	Hour	5700	915.00	14.25	**74320875.00**	
Skilled Nursing Total:						**20150.00**
Skilled Nursing	Hour	10	65.00	31.00	**20150.00**	
Temporary Assistance (formerly called Crisis Services) Total:						**79200.00**
Temporary Assistance (formerly called Crisis Services)	Hour	20	360.00	11.00	**79200.00**	
Training and Counseling Services for Unpaid Caregivers Total:						**12500.00**
Counseling Services for Unpaid Caregivers	Per Event	25	10.00	30.00	**7500.00**	
Training Services for Unpaid Caregivers	Per Event	25	1.00	200.00	**5000.00**	
Vehicle Modification Total:						**225000.00**
Vehicle Modification	Per Item	25	1.00	9000.00	**225000.00**	
				GRAND TOTAL:		**652192095.00**
				Total Estimated Unduplicated Participants:		**20840**
				Factor D (Divide total by number of participants):		**31295.00**
				Average Length of Stay on the Waiver:		335