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:
Residential Waiver for Children and Young Adults with Developmental Disabilities

C. Waiver Number: IL.0473
Original Base Waiver Number: IL.0473.

D. Amendment Number: IL.0473.R01.01

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

07/01/10

Approved Effective Date: 07/01/10
Approved Effective Date of Waiver being Amended: 07/01/10

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
Purpose:
The Illinois HCBS Residential Waiver for Children and Youth with Developmental Disabilities (0473)is being amended to revise the waiver appendices where action plans were initiated and completion dates were documented in the waiver.

HFS is removing the action plan timelines from the approved application and adding language that references an action plan that is separate from the approved waiver application. The specific sections that are being amended are Appendices F-3, G-1 and G-2.

Background and Justification for Change:
The Medicaid and Operating agencies met with CMS by telephone on March 23, 2011, and agreed to provide CMS with updated dates on the action plan for both DD children's waivers (0473 and 0464). CMS recommended that both waivers be amended and that the action plans be updated separate from the waivers to include quarterly due dates, rather than date-specific due dates.

In a folow-up email dated April 5, 2011, CMS regional office staff suggested that the State use the following language when referencing the changes to the action plans:

"In order to further enhance its critical incident management system the HFS submitted an action plan to CMS with the waiver renewal. The action plan outlines the activities that HFS is undertaking to establish a formal process for state level review."

This language has been inserted in the appropriate sections and the language submitted with the initial renewal has been removed.

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	
☐ Appendix C – Participant Services	
☐ Appendix D – Participant Centered Service Planning and Delivery	
☐ Appendix E – Participant Direction of Services	
☑ Appendix F – Participant Rights	F-3
☑ Appendix G – Participant Safeguards	G-1, G-2
☐ Appendix H	
☐ Appendix I – Financial Accountability	
☐ Appendix J – Cost-Neutrality Demonstration	

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:
Revise sections where the State had specific Action Plans with target dates. The action items and target dates are being removed from the waiver and submitted to federal CMS through a separate process.

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*):
Residential Waiver for Children and Young 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.0473
Waiver Number: IL.0473.R01.01
Draft ID: IL.22.01.01

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/10
Approved Effective Date of Waiver being Amended: 07/01/10

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**

- [x] **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

  If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

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:
☑ **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 Children's Residential Waiver provides 24-hour residential supports to eligible children and young adults with developmental disabilities from age three through age 21. The supports provided are designed to prevent or delay the need for residential services in an ICF/MR. Children who are wards of the State are not eligible for this program.

The number of participants served each year is based on available State appropriation levels.

The Division of Developmental Disabilities, within the Illinois Department of Human Services, operates the Children's Residential Waiver.

Contracted independent service coordination (ISC) agencies across the State and under contract with the Operating Agency serve as the local point of access for children and their families. All participants and families receive assistance in directing service delivery from Individual Service and Support Advocates (ISSA) at these agencies.

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/MR.

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

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

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, 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 from the Statewide Advisory Council (SAC) on Developmental Disabilities, local network advisory councils, the Waiver Ad-Hoc Committee, and a series of focus groups on the Strategic Plan arranged by the Operating Agency.

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

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

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

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: Roehrs

First Name: Linda

Title: Bureau Chief

Agency:

	Department of Healthcare and Family Services
Address:	Bureau of Interagency Coordination
Address 2:	201 South Grand Avenue East, 3rd Floor
City:	Springfield
State:	**Illinois**
Zip:	62763
Phone:	(217) 557-1863 **Ext:** ☐ **TTY**
Fax:	(217) 557-8604
E-mail:	Linda.Roehrs@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 Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

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

Signature:	Ann Lattig
	State Medicaid Director or Designee
Submission Date:	Jul 6, 2011

Last Name:	Eagleson
First Name:	Theresa
Title:	State Medicaid Director
Agency:	Department of Healthcare and Family Services
Address:	Division of Medical Programs

Address 2: 201 South Grand Ave East, 3rd Floor
City: Springfield
State: **Illinois**
Zip: 62763
Phone: (217) 782-2570
Fax: (217) 782-5672
E-mail: Thersa.Eagleson@illinois.gov

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

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:
     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, Illinois' Medicaid Agency, conducts the following activities:

   •The Medicaid Agency reviews and approves all changes to Medicaid policies, rules and regulations prior to implementation.
   •The Medicaid Agency conducts appeals involving waiver services and issues final administrative decisions, providing the independent hearing officer for all appeal hearings.
   •The Medicaid Agency reviews and approves changes to the Operating Agency's payment rate methodologies.
   •The Medicaid Agency conducts on-going program monitoring by participating jointly with the Operating Agency as possible in all onsite monitoring reviews of a representative sample of participants, and by using performance measures and sampling described in Appendix A.
   •The Medicaid Agency conducts annual fiscal monitoring by conducting validation reviews from the Operating Agency post-payment audit report that is based on representative sample of participants, and by using performance measures and sampling described in Appendix A.
   •Staff from the Medicaid Agency are members of the Quality Management Committee. The committee is responsible for the overall coordination of quality management activities. Current members of the Quality Management Committee (QMC) include key staff from both the OA and MA. This includes representatives from the Medicaid Agency's Bureau of Interagency Coordination and the Operating Agency's Bureau of Quality Management, and the Operating Agency'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 based on the evidence presented.
   • As part of the activities described in the previous dot point, the Medicaid Agency reviews data regarding prior authorization of waiver services by the Operating Agency, including time frames for authorizations.

   •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. Medicaid Agency staff attempt to attend all Statewide Advisory Council meetings; however should an absence be necessary, a meeting summary is provided.
   •The Medicaid Agency participates with the Operating Agency in training and informational sessions.
   •The MA is not a formal member of the Statewide Advisory Council on Developmental Disabilities (DD) but voluntarily participates as a way to keep informed of issues impacting individuals with developmental disabilities being discussed by the council. The Statewide advisory Council on Developmental Disabilities 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. The MA considers it a priority to attend, however, attendance is optional.

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.:*
     Under contract with the Operating Agency, private entities complete eligibility determinations, as well as service coordination and monitoring functions. These functions are performed by Qualified Mental Retardation Professionals (QMRPs).

     In addition, the Operating Agency uses contracted vendors as consultants, selected in accordance with the State's procurement policies, to consult and provide technical assistance in establishing provider qualifications standards and 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 the contracted 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 Agency's screening manual and ISSA Guidelines, as well as contractual requirements. The survey protocol includes staff qualifications and training, 24-hour accessibility for emergencies, a review of the pre-admission screening process (documentation of required assessments, eligibility determinations, informed choice and selection of services, and conflict of interest), and review of the Individual Service and Support Advocacy process (documentation of required visits, participation in support plan development and approval, and annual re-determinations of eligibility).
   Agencies are notified in writing of any deficiencies and are required to submit a plan of correction, including timeframes, if the agency scores less than 90% on their overall performance. Operating Agency staff review the plan of correction and, if acceptable, approve it.

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

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of reports submitted to the MA with evidence of timely remediation in the areas of pre-admission screening and waiver enrollment.

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
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:
Number and percent of semi-annual fiscal reports generated by the MA where waiver enrollment, utilization and expenditures meet estimated levels in the approved waiver.

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:
Number and percent of reports submitted to the MA with evidence of timely remediation 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:
Number and percent of reports submitted to the MA with evidence of timely remediation 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:
Number and percent of reports submitted to the MA with evidence of timely remediation 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:
Number and percent of waiver program providers with a Medicaid provider agreement on file at the MA.

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:
Number and percent of rate methodology changes submitted to the MA approved prior to implementation by MA and submitted for Public Notice.

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:
Number and percent of waiver program policies submitted to the MA prior to OA dissemination and implementation.

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:
Number and percent of requests for services subject to prior authorization that are decided timely.

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:
The number of quality reviews conducted as compared to what was specified in the waiver.

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:

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 OA conducts site visits based on a representative sample of participants in the waiver. A planned schedule of all on-site reviews is provided to the MA at the beginning of each waiver year. Joint reviews will be conducted by the MA and OA. The MA will participate in all reviews, as possible.

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 timely remediation of issues found during their monitoring. This includes assuring that individual issues are resolved. All data collected including the timeliness of remediation activities is summarized quarterly and shared with the Quality Management Committee which meets quarterly. The data is analyzed and evaluated for trends on a quarterly and annual basis. As trends are identified, proactive remediation is initiated. The OA provides quarterly summary reports of their activities to the Medicaid agency. The Medicaid Agency reviews the quarterly reports and determines the appropriate follow-up. General remediation activities may include, recommending that the OA clarify policy, retrain staff, provide technical assistance, void claims, increase monitoring, conduct focused reviews with the MA, or develop a plan of correction.

As individual problems and trends are identified, proactive remediation is initiated. The State establishes remediation plans by identifying the responsibilities of the Medicaid and Operating Agencies and identifying timeframes for completion. The Quality Management Committee collectively tracks the remediation activity and monitors results of remediation and system changes.

The MA monitors the OA compliance with remediation procedures and established timelines related to individual problems. If there are issues found, the Medicaid Agency works with the Operating Agency to rectify the issues.

Remediation timelines are monitored during Quality Management Committee on a quarterly basis. Evidentiary reports summarize remediation timelines as follows: with 30 days, between 31-60 days, more than 60 days and outstanding.

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.

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 a group 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 waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

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**			☐
(●) **Mental Retardation or Developmental Disability, or Both**					
	☑	**Autism**	3	21	☐
	☑	**Developmental Disability**	3	21	☐
	☑	**Mental Retardation**	3	21	☐
( ) **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 need active treatment, must be in need of children's residential Waiver supports, must reside within the State of Illinois, and must not be in need of nursing assessment, monitoring, intervention and supervision of their condition or needs on a 24-hour basis. Children who are wards of the State are not eligible.

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 basis, 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:

The Children's Residential Waiver includes children and young adults with developmental disabilities through the age of 21. Adult Developmental Disabilities Waiver services may start at age 18. This four-year transition period is designed to enable participants in the Children's Residential Waiver to transition easily to other programs including other waivers for adults, as appropriate, or ICF/MR services. We expect that most participants will choose to transition as they exit the special education system. The State has designed the Children's Residential Waiver so that, as much as possible, eligibility criteria, service definitions, provider qualifications, case management roles and responsibilities, and service implementation are consistent across Waiver programs.

During the course of Waiver services, each participant is assigned an Individual Service and Support Advocate (ISSA) who serves as an independent advocate, participates in support plan development, and monitors service provision. The ISSA will assist the participant and family during the transition period. The ISSA will inform the participant and family about adult service options and ensure necessary eligibility screenings are completed.

Young adults aging out of this Waiver are given priority status for Adult Developmental Disabilities Waiver Services over other individuals enrolled in the State's Prioritization of Urgency of Need for Services (PUNS) database. If an applicant is ineligible for the Adult Waiver, assistance is provided to access non-waiver services, State Plan services, or to other waiver services as appropriate. Other waiver services include those offered under the State's Persons with Disabilities Waiver and the Persons with Brain Injury Waiver. Independent Service Coordination entities provide assistance and planning for transition.

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	258
Year 2	258
Year 3	258
Year 4	258
Year 5	258

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)*:

- (selected) **Not applicable. The state does not reserve capacity.**
- ( ) **The State reserves capacity for the following purpose(s).**

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)*:

- (selected) **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:

- (selected) **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:

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 basis, including urgency of need, length of time on the database, and randomness.

As appropriations are available, children are selected for authorization for Waiver services via an automated process that focuses on the child's needs and the family's circumstances. Entrance to the Children's Residential Waiver 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 manual regarding PUNS is available upon request from the Operating Agency.

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)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☑ **Medically needy 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)**
- ☐ **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:

  [ ]

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**

- [x] **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: [ ]

- [x] **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)**
- [x] **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 4)

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

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

- ○ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the State elects to (*select one*):

- **Use spousal post-eligibility rules under §1924 of the Act.**
  (Complete Item B-5-c (209b State) and Item B-5-d)
- **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
  (Complete Item B-5-c (209b State) . Do not complete Item B-5-d)

- **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
  (Complete Item B-5-c (209b State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

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

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

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

- **The following standard included under the State plan**

  (*select one*):

  - **The following standard under 42 CFR §435.121**

    Specify:

    [ ]
  - **Optional State supplement standard**
  - **Medically needy income standard**
  - **The special income level for institutionalized persons**

    (*select one*):

    - **300% of the SSI Federal Benefit Rate (FBR)**
    - **A percentage of the FBR, which is less than 300%**

      Specify percentage: [ ]
    - **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - **A percentage of the Federal poverty level**

Specify percentage: 100

- **Other standard included under the State Plan**

  Specify:

- **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.

- **The following formula is used to determine the needs allowance:**

  Specify:

- **Other**

  Specify:

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

- **Not Applicable (see instructions)**
- **The following standard under 42 CFR §435.121**

  Specify:

- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

  Specify:

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

- **Not Applicable (see instructions)**
- **AFDC need standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- **The amount is determined using the following formula:**

  Specify:

- **Other**
  Specify:

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

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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-5-a indicate that you do not need to complete this section 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 reevaluations are performed by local ISC entities under contract with the Operating Agency. Issues, findings and status of remediation will be shared with the MA on a quarterly basis.

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 Support Professionals (QSP).

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.

The level of care criteria used to evaluate and reevaluate whether an individual needs services through the Waiver will be the same as those used to determine whether an individual is eligible for an ICF/MR setting known in Illinois as Long Term Care Under Age 22 facilities. Individuals receive a screening to determine eligibility, using procedures and forms provided in the Operating Agency's Procedure Manual. A copy of the manual and the tools are on file with the Medicaid Agency and Operating Agency.

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 QMRPs to complete the evaluations and reevaluations. Each individual will be evaluated to determine his or her functional level in relation to the individual's chronological age, especially in the areas of comparative level of independence, comparative functional skills, and comparative need for the immediate support of a responsible adult. Individuals who have been shown to have mental retardation (both cognitively and functionally) or individuals who have been determined to have a related condition (including meeting all four criteria) may be determined to require Active Treatment. The timeliness for psychological assessments (to determine mental retardation) and for functional assessments (to determine substantial functional limitations in three out of six major life activity areas) must be dated within one year prior to the PAS for children ages three through 12 and within two years for children ages 13 up to age 18.

The screening agencies must use a formal functional assessment tool for adaptive functioning suitable for children.
The re-determination criteria are the same as the initial eligibility criteria.

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 re-evaluations are conducted yearly. The edit requires the contracted entity to enter the re-evaluation date. If that date is more than one year old, the edit will not allow payments to be made to the entity.

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 re-evaluation forms are kept by contracted entities for the mandatory three years or more. Results are maintained electronically by the Operating Agency for three or more years.

Appendix B: 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**
   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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of new waiver participants reviewed who had a level of care assessment

indicating a need for ICF/MR level of care prior to receipt of services.

Data Source (Select one):
Program logs
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 levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of waiver participant reviewed 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.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Automated reporting system

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 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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of waiver participants' initial (or annual, or both) LOC determinations forms/instruments that are completed as required by the state.

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:
Number and percent of LOC determinations made by a qualified evaluator.

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.

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 reviews the issues and identifies the most appropriate response. General responses may include work with participants and their providers, retraining staff, voiding claims, technical assistance, increased monitoring, revising service plans, and requiring plans of correction. The OA is responsible for seeing that these individual issues are resolved. The OA provides quarterly reports of these activities to the MA. Staff of the two State agencies review the reports on a quarterly basis.

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 QMRPs employed by the Operating Agency's contracted ISC entities inform individuals and/or their legal guardians, about their options during the level of care determination process. The QMRP presents individuals/legal representatives 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 QMRP makes accommodation for that. Acceptable accommodation may include use of

staff with secondary language skills, translation services, oral assistance and communication devices.

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 Freedom of Choice IL462-1238(R-11-07) forms, available in both English and Spanish, are maintained by the contracted ISC 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 ISC entities under contract with the Operating Agency that serve as access points are integrated in their communities and on a daily basis interact with a wide variety of individuals of varying backgrounds, cultures, and languages. The entities have resources available to communicate effectively with individuals of limited English proficiency in their community, including bilingual staff as needed, interpreters, translated forms, etc.

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

Appendix C: Participant Services

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	**Child Group Home**
Extended State Plan Service	**Adaptive Equipment**
Other Service	**Assistive Technology**
Other Service	**Behavior Intervention and Treatment**

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):

Child Group Home

Service Definition *(Scope):*

Residential habilitation means case management and individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, and 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. Payment is not made, directly or indirectly, to members of the participant's immediate family.

Residential habilitation may include the reduction of maladaptive behaviors through positive behavioral supports and other methods.

Residential habilitation includes transportation between the residence and other community locations where habilitation occurs, excluding transportation to and from school. These other community locations may include, generic services, stores, and recreational and socialization activities. Transportation is included as an integral component of Child Group Home services. Training and assistance in transportation usage are provided as needed.

Residential habilitation may be provided in a Child Group Home, a residential setting licensed by the Department of Children and Family Services that serves no more than ten children. It is designed to provide a structured environment and a range of habilitative and therapeutic services to children and adolescents who cannot reside in their own home. Child Group Home services do not include 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.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Residential Habilitation services are available to participants who request this service and are selected according to the process described in Appendix B.

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	Child Group Home

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Child Group Home

Provider Category:
Agency
Provider Type:
Child Group Home
Provider Qualifications
License *(specify):*
89 Ill. Adm. Code 401
89 Ill. Adm. Code 403
Certificate *(specify):*

Other Standard *(specify):*
89 Ill. Adm. Code 331 – Unusual Incidents
89 Ill. Adm. Code 384 – Behavior Treatment in Residential Child Care Facilities
Contract requirements
Verification of Provider Qualifications
Entity Responsible for Verification:
The Operating Agency and the Department of Children and Family Services (state licensure agency)
Frequency of Verification:
Annually focused survey and licensure every four years

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:

Adaptive Equipment

Service Definition *(Scope):*

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

Items reimbursed with Waiver funds do not include any adaptive equipment and supplies furnished under the State Plan or by the school program 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 service may include the performance of assessments to identify the type of equipment needed by the participant.

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

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

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

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

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	Equipment vendors

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Adaptive Equipment

Provider Category:

Agency

Provider Type:

Equipment vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled vendor approved by the support planning team and participant/family

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency

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:

Assistive Technology

Service Definition *(Scope):*

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

(A) 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;

(B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;

(C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

(D) 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 participant-centered support plan;

(E) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and

(F) training or technical assistance for professionals or other persons who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

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

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

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

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

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

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

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	Equipment vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:
Equipment vendor
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled vendor approved by the support planning team and the participant/family.
Verification of Provider Qualifications
Entity Responsible for Verification:
Operating Agency
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
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 a 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 family training is a key component so that skills can be generalized and communication promoted;
• Services must be directly related to the participant's therapeutic goals contained in the support plan and coordinated with the participant's individual education plan (IEP); and
• Success is closely monitored with detailed data collection.

A behavior consultant assesses the participant, including analysis of the presenting behavior and its antecedents and consequences, and develops written behavior strategies based upon the participant's individual needs. The strategies are a component of the participant–centered support plan and must be approved by the participant, family, responsible QMRP, Individual Service and Support Advocate and the other members of the planning team. Trained team members implement the planned behavior services. The behavior consultant monitors progress on at least a monthly basis and more frequently if needed to address issues with the participant's outcomes. A progress report is prepared by the behavior consultant and sent to

the support planning team every six months. This progress report is available to State staff upon request to evaluate the efficacy of the treatment.

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

Professionals working closely with the participant's direct support staff, family, teachers and other school personnel provide services in the participant's home and other natural environments (excluding school).

Direct support staff and families of participants receiving intensive behavior treatment are vital members of the behavior team. They must be involved in the initial training session to initiate services, and must remain involved with the team so that they are able to carry through and reinforce the behaviors being worked on by the team.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There is an annual State fiscal year maximum of 66 hours.
No direct treatment may be delivered during the typical school day relative to the age of the child or during times when educational services are being provided. Indirect services such as writing recommendations, planning and consultations with school personnel are permitted. Planning for school services and training for school staff may not be included.

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
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):*

Other Standard *(specify):*
Clinical psychologist
Masters level professional who is certified as a Behavior Analyst by the Behavior Analyst Certification Board (bacb.com)
Bachelor's level professional who is certified as an Associate Behavior Analyst by the Behavior Analyst Certification Board (bacb.com)
Professional who is certified to provide Relationship Development Assessment. Information is at rdiconnect.com.
Early Intervention Specialist with a Developmental Therapy credential or equivalent experience and training.
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 effectiveness for children with Autism Spectrum Disorder.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency (DHS)

Frequency of Verification:

Upon enrollment and annual verification of national certification or continuation of licensure.

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:

  - ☐ **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.*
  - ☑ **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:

In addition to residential habilitation, which provides many components of case management services, each waiver participant receives Individual Service and Support Advocacy (ISSA) services from independent ISC local entities under contract with the Operating Agency. ISSAs are Qualified Mental Retardation Professional (QMRP) staff, who are responsible for the annual re-determinations of level of care, participate in the support planning process, approve all participant-centered support plans, 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 Operating Agency about issues that require additional monitoring and technical assistance. The maximum for ISSA is 25 hours per state fiscal year, unless written approval is granted for additional hours. This administrative service is required for all waiver participants.

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):

Child Group Home providers are required to comply with the Child Sexual Abuse Prevention Act (325 ILCS 15/) and the Illinois Health Care Worker Background Check Act (225 ILCS 64/25). A copy of the Acts are available upon request. Child Group Home staff are required to have criminal background checks with the Illinois State Police. Child Group Home staff for whom criminal background checks are required include paid or unpaid persons age 17 or older who perform essential staff duties and have access to children. These providers may not employ any person in a position that allows access to children if that person has been convicted of committing or attempting to commit one or more of the offenses listed in the Background Check rule (89 Ill. Adm. Code 385).

The Illinois Department of Children and Family Services includes verification of staff background checks as a component of

the provider qualifications review and approval conducted on an annual basis. A sample of records for each provider is reviewed during this annual approval. Periodically, the OA & MA review providers for compliance with this requirement.

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 Children and Family Services (DCFS) maintains a child abuse and neglect registry. The registry is called the Child Abuse and Neglect Tracking System, or CANTS.

By statute, the Illinois Department of Public Health maintains an adult abuse and neglect registry. The registry is called the Healthcare Worker Registry.

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 Child Group Home employees hired on or after July 1, 2007. Individual Service and Support Advocacy staff are also subject to this requirement. 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.

The OA and MA review providers for compliance with this requirement.

The state law governing the IDPH Health Care Workers' Registry is the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30). The state law governing the State Central Register (DCFS CANTS) is the Abused and Neglected Child Reporting Act (325 ILCS 5/1).

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	
Licensed Child Group Home	

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.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Child Group Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Assistive Technology	☑
Adaptive Equipment	☑
Behavior Intervention and Treatment	☑
Child Group Home	☑

Facility Capacity Limit:

10

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:

Facility standards require that the provider have a written admission policy, but do not specify the contents of the policy. The Operating Agency is responsible for review and approval of requests for admission to Child Group Home services for waiver applicants/participants. This approval is based on assessment information and waiver

eligibility determinations conducted by local independent contracted entities across the state.

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.

- ( ) **Other policy.**

Specify:

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

Participants in the Children's Residential Waiver and their legal representative, together with the responsible QMRP, Individual Service and Support Advocate (ISSA), and other members of the support planning team, are responsible for selecting needed services and service providers, as part of the participant-centered planning process.

Information regarding provider qualifications for Child Group Homes is continuously available on the Department of Children and Family Service's website. Information regarding provider qualifications and program guidelines for other Waiver services is continuously available on the Operating Agency's website.
The State does not impose barriers to the free choice of willing and qualified providers.

The Operating Agency (DHS) reviews and approves service providers for participation in the Waiver based on the provider qualifications specified in the Waiver.

The Medicaid Agency enrolls all willing and qualified providers that are chosen by participants in the Waiver and their families.

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**
   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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of licensed or certified providers who meet initial licensure/certification standards.

Data Source (Select one):
Program logs
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:
Number and percent of licensed or certified providers who continue to meet licensure/certification standards on an ongoing basis.

Data Source (Select one):
Program logs
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 monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
The number and percent of non-licensed/non-certified providers reviewed, by provider type, who meet initial provider qualifications.

Data Source (Select one):
Program logs
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:
The number and percent of non-licensed/non-certified providers reviewed, by provider type, who continue to meet waiver provider qualifications.

Data Source (Select one):
Program logs
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:

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of providers reviewed, by provider type, who meet waiver provider training requirements.

Data Source (Select one):
Training verification records
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.

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 reviews the issues and identifies the most appropriate response. General responses may include work with participants and their providers, retraining staff, voiding claims, technical assistance, increased monitoring, revising service plans, and requiring plans of correction. The OA is responsible for seeing that these individual issues are resolved. The OA provides quarterly reports of these activities to the MA. Staff of the two State agencies review the reports on a quarterly basis.

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.

- [ ] **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.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Participant-Centered Individual Support 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:

  Responsible QMRP (in Illinois known as a Qualified Support Professional) as defined in federal regulations who is employed by child group home provider.

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:*

  A QMRP, called Individual Service and Support Advocate (ISSA) who works for a local ISC independent entity under contract with the Operating Agency participates in and approves the participant-centered support plan. The QMRP also conducts quarterly visits to the participant to ensure that services in the plan are being fully implemented and are meeting the participant's needs.

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.

Participant-centered support plans are developed by QMRPs, who work as part of a team that includes the participant being served, the participant's family or legal representative, participant's Individual Service and Support Advocate (ISSA), other individuals from the participant's support network as the family or guardian chooses, and direct support staff and professional consultants as deemed necessary by the provider. The written plan may be produced in other formats, such as pictures, DVD, etc., to accommodate specific needs of the participant, team, or provider; however, the plan must exist in written format.

ISSAs are directed to contact the family or legal representative prior to any support planning meetings to identify areas of concern, answer questions, and generally prepare for the meeting.
The participant and/or legal representative, responsible QMRP and the ISSA must approve the support 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 QMRP shall prepare a written participant-centered support plan (ISP) for each participant served only after consultation with the following:
• The participant;
• The participant's family or legal guardian, if one has been appointed;
• Other individuals from the participant's support network as the family or legal representative chooses (including school personnel as appropriate);
• The participant's ISSA; and
• Professional consultants and direct support staff as deemed necessary.

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

The support plan shall:
• Contain a description of the participant's preferences;
• List and describe the necessary activities, training, materials, equipment, assistive technology, and services that are needed to assist the participant;
• Describe how opportunities of choice will be provided, including specifying means for the following:
• supporting the family to indicate preferences among options presented, by whatever communication methods necessary;
• providing the necessary support and training for the family 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 and family 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 and family's preferences;
• Provide for supports for the participant to access school-based services, generic resources, and Medicaid State Plan services;
• Contribute to the continuous movement of the participant toward the achievement of the participant and family's preferences.

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

The ISSA shall approve only those support plans that meet the requirements established in the Waiver. If the ISSA determines the proposed plan does not meet these requirements, the ISSA shall work with the participant, family and 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 the responsible QMRP shall make a referral to the Operating Agency for technical assistance.

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

In developing, modifying, and evaluating the effectiveness of the support plan, the responsible QMRP shall include assessments made by professionals and shall:
• Include consideration of the expressed opinions of the participant and family; 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 and family;
(iii) the participant's medical status;
(iv) the participant's ability to communicate his or her needs and preferences; and
(v) matters identified above in accordance with imminent danger.

Next best options may be considered as responsive if the participant and family cannot specifically have what the participant and family prefer due to limitations identified.
All plans must be updated at least annually.

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.

The responsible QMRP and ISSA must address during the planning process with the participant and family the negative consequences of choices that may involve risk and document the issues concerned and the decisions made. They will describe, when it is necessary to do so, to the participant, family 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, family or guardian's history of decision-making and ability to learn from the natural negative consequences of poor decision-making;
• The possible long and short-term consequences that might result to the participant if the participant, family or guardian 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, family or guardian from making a choice; and
• The safeguards available to protect the participant's safety and rights in each context of choices.

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 written list of providers is available upon request. Participants are supported by the Independent Service Coordinator 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 entity informs the individual or guardian of providers offereing that type of service in the desired geographic are. ISC entities will make referrals to those providers selected by the individual or family. These referrals must be documented on the DDPAS-10. The ISC ensures linkage with potential providers, and may, at the individual's or family's request, participant in discussions or visit with the providers. A copy of the DDPAS-10 must be maintained in the individual's file at the ISC entity's office.

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 Operating Agency review the adequacy of support plans through a representative sample during on-site reviews as possible. The Medicaid Agency staff participate in the review. The reviews consist of record reviews, interviews with participants and staff, and observations. Data from these reviews are aggregated by the Operating Agency and shared with the Medicaid Agency staff as part of the Quality Management Committee activity. This committee meets quarterly.

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:

Provider agency (child group home provider) and ISC entity under contract with the Operating Agency.

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 employed by the Child Group Home provider is responsible for implementing the service plan and ensuring the health and welfare of the participant. They are to have face-to-face contact with the participant on a monthly basis or more frequently as needed.

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

The OA monitors the case management and ISSA activity through a representative sample of participants on a continuous, on-going basis. Data is collected and analyzed as specified under the Quality Improvement sections in Appendices D and G on an on-going, continuous basis. Summary reports are shared with the MA quarterly and discussed during Quality Management Committee meetings. When problems are identified, they are documented and remediation efforts are initiated by the OA. Remediation efforts may include revising service plans, increased monitoring, technical assistance, plans of correction, voidance of claims.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant.
Specify:

In addition to routine monitoring by the responsible QMRP at the Child Group Home provider agency, the ISSA, employed by an ISC entity under contract with the Operating Agency, continually (at least quarterly or more often if necessary) monitors participant health and welfare and the implementation of the support plan. The ISSA works cooperatively with the

service providers and the family to resolve any concerns. In the event issues cannot be resolved, the provider or 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**
   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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of the participant plans of care reviewed that address all participant needs identified by the assessments.

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:
Number and percent of family guardian satisfaction surveys sampled who report they receive services to address their needs.

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:
Number and percent of participants reviewed whose service plan have strategies to address all health and safety risks indicated in the assessment.

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of ISP's reviewed that were signed by participant, parent/guardian (if applicable), ISSA, and residential provider QMRP (in Illinois known as a Qualified Support Professional).

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:

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of waiver participants reviewed who have their Service Plan updated at least annually.

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of participants reviewed who received four quarterly visits from the ISC entity under contract with the Operating Agency to monitor that services are being delivered in accordance with the services in the plan of care.

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/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of waiver participants who have a completed and signed freedom of choice form specifying that choice was offered between institutional care and waiver services at the time of enrollment.

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:
Number and percent of waiver particpants who have a completed and signed freedom of choice form that specifies choice was offered among waiver services and providers upon enrollment.

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.

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 reviews the issues and identifies the most appropriate response. General responses may include work with participants and their providers, retraining staff, voiding claims, technical assistance, increased monitoring, revising service plans, and requiring plans of correction. The OA is responsible for seeing that these individual issues are resolved. The OA provides quarterly reports of these activities to the MA. Staff of the two State agencies review the reports on a quarterly basis.

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)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

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:
• Provider agency staff is responsible for informing participants of the right to appeal upon Waiver enrollment. The Operating Agency has developed a standard form, Notice of Individual Right to Appeal (IL-462-1202 (R-9-08)) available in English and Spanish for this purpose. The standard form states: If an appeal request is received within 10 calendar days after receipt of the notice of action, the decision in the notice shall be stayed, pending the results of the appeal.
• Pre-admission screening staff are responsible for written notification when there is:
• Determination of ineligibility for Waiver services.
• Denial of choice of Waiver or institutional services.

• Denial of choice of Waiver services or providers.
• Provider agency staff are responsible for written notification when there is a denial, reduction, suspension or termination of service by that provider.
• Operating Agency staff and Medicaid Agency staff are responsible for written notification when there is an adverse decision in the fair hearing process.

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

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

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

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

The participant has ten working days to appeal the informal review decision to the Medicaid Agency for final administrative action. The request for an appeal to continue existing services allows those services to continue until the hearing decision is reached or unless the appeal is withdrawn.

The Medicaid Agency appoints an impartial hearing officer to conduct the hearing at the Medicaid Agency or Operating Agency office nearest to the family's home unless all parties agree to an alternate location. The hearing officer may participate by video conference.

The Medicaid Agency hearing officer conducts the formal appeal, drafts the 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 Operating Agency of the final decision. The final administrative decision by the Medicaid Agency may be appealed to the State Circuit Court.

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 the Medicaid Hearing Officer Manual, 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:
o the Medicaid Hearing Officer drafts the case
o the Medicaid Hearing Supervisor reviews 100% of the cases
o 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.

In the recent months, HFS has hired new senior staff members who are in the process of reviewing and reassessing the Fair Hearings and all applicable administrative rules and regulations governing its hearings.

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.

The ISC entities, under contract with the OA, are responsible for hearing and resolving issues that arise at the local providers. The Operating Agency is responsible for providing technical assistance when the ISC entities cannot successfully resolve local issues. The OA maintains a database of complaints referred by ISCs or made directly by participants. Reports from the database are shared monthly by the OA with the MA. The data is analyzed and evaluated for trends on a quarterly and annual basis. As individual problems and trends are identified, proactive remediation is initiated. The State establishes remediation plans by identifying the responsibilities of the Medicaid and Operating Agencies and identifying timeframes for completion. The Quality Management Committee collectively tracks the remediation activity.

In order to further enhance its Grievance and Complaint system, the HFS submitted an Action Plan to CMS with the waiver renewal. The Action Plan outlines the activities that HFS is undertaking to establish a formal process for state level review. The Action Plan has been incorporated into the waiver by reference. The OA and MA will report progress on this Quality Improvement Strategy in the annual 372 reports.

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

Each participant enrolled in the Waiver meets with ISSA staff employed by an ISC entity under contract with an OA a minimum of four times each year – approximately once per quarter.

Participants or their legal representatives may at any time contact ISSA staff to discuss unresolved issues or problems affecting the participant's health and welfare. ISSA staff work with the locdal residential provider to resolve grievances/complaints, particularly those between the participant and service providers. If the grievance continues, ISSA staff continue the process by involving agency supervisory staff of increasing authority, up to and including the executive director of the residential provider. If the grievance cannot be resolved, ISSA staff should contact Operating Agency staff for technical assistance or intervention. The participant, family or guardian may contact Operating Agency staff to file a complaint at any time during this process. Referrals are tracked on a referral database by the Operating Agency.

Complaints, whether from ISSA or directly from participants, are tracked on a referral database by the Operating Agency. Reports from this database will be shared with the MA on a monthly basis. The reports will summarize information by type of incident, provider and action taken.

As individual problems and trends are identified, proactive remediation is initiated. The State establishes remediation plans by identifying the responsibilities of the Medicaid and Operating Agencies and identifying timeframes for completion. The Quality Management Committee collectively tracks the remediation activity and monitors results of remediation and system changes. The

Medicaid Agency monitors the Operating Agency compliance with remediation procedures and established timelines related to individual problems. If there are issues found the Medicaid Agency works with the Operating Agency to rectify the issues.

Participants are informed that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing.

In order to further enhance its Grievance and Complaint system, the HFS submitted an Action Plan to CMS with the waiver renewal. The Action Plan outlines the activities that HFS is undertaking to establish a formal process for state level review. The Action Plan has been incorporated into the waiver by reference. The OA and MA will report progress on the Quality Improvement Strategy in the annual 372 reports.

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).

The types of critical incidents that must be reported include any specific incident of abuse or neglect or a specific set of circumstances involving suspected abuse or neglect, where there is demonstrated harm to the participant or a substantial risk of physical or sexual injury including sexual exploitation of the participant. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the participant's welfare at the time of the alleged abuse or neglect, or any person who came to know the participant through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

Although anyone may make a report, mandated reporters are professionals who may work with children in the course of their professional duties. There are seven groups of mandated reporters defined in the Abused and Neglected Child Reporting Act - ANCRA (325 ILCS 5/4). They include: medical personnel, school personnel, social service/mental health personnel (including staff of both the Medicaid Agency and the Operating Agency), law enforcement personnel, coroner/medical examiner personnel, child care personnel (including all staff at overnight, day care, pre-school or nursery school facilities, recreational program personnel, foster parents), and members of the clergy.

Mandated reporters are required to report suspected child maltreatment immediately when they have reasonable cause to believe that a child known to them in their professional or official capacity may be an abused or neglected child. This is done by calling the Department of Children and Family Services 24-hour hotline (800-25-ABUSE). Reports must be confirmed in writing to the local investigation unit within 48 hours of the hotline call.

The Department of Children and Family Services (DCFS) investigates all allegations of abuse or neglect or sexual exploitation for children and young adults (through the age of 21) who reside in residential settings licensed by DCFS.

Information on the State's protective services and how to report is shared with participants and/or family members at the time of waiver enrollment and placement in a child group home. The QMRP employed by the waiver provider is responsible to provide the information. ISSA employed by Independent Service and Support Coordination entities under contract with the OA are available to provide information and training on how to report.

The MA and the OA will work with the DCFS to develop a relationship and strategies on sharing information in order to improve remediation activities with providers serving participants.

In order to further enhance its Incident Reporting Management System, the HFS submitted an Action Plan to CMS with the waiver renewal. The Action Plan outlines the activities that HFS is undertaking to establish a formal process for state level review. The Action Plan has been incorporated into the waiver by reference.

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 their families (or guardian, if one has been appointed) are informed by both Child Group Home provider staff and ISSA staff about protections from abuse and neglect. The information provided includes the process for reporting allegations to the Department of Children and Family Services hotline for participants. Participants and families or guardians are informed that anyone who suspects abuse, neglect or exploitation may report an allegation.

Information is presented both verbally and in writing initially and upon request. Information on the State's protective services and how to report is shared with participants and/or family members at the time of waiver enrollment and placement in a child group home. The QMRP employed by the waiver provider is responsible to provide the information. Information on the State's hotline is available on multiple websites and is also listed in the Waiver Provider Manual. ISSA employed by Independent Service and Support Coordination entities under contract with the OA are available to provide information and training on how to report. The OA monitors to assure that individuals have received appropriate training.

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.

For all Waiver Participants.

The Department of Children and Family Services (DCFS) is the state agency that is responsible for conducting investigations of child maltreatment and arranging for needed services for children and families where credible evidence of abuse or neglect exists (indicated cases). DCFS provides protective services at the request of the subjects of the report, even when the report has been unfounded.

DCFS field office staff are required to make initial contact and start the investigation of the allegation within 24 hours of the hotline report. In an emergency situation, then initial contact must be made within an hour of the report.

Most investigations are conducted in 60 days unless there is just cause for a 30 day extension to make a determination whether the allegation is indicated or unfounded. Appropriate emergency services are provided while the investigation is pending. Emergency and ongoing services may include protective plans.

Participants and families (as appropriate) are notified within five calendar days of the completed investigation.

Serious allegations such as sexual abuse, sexual exploitation, serious physical harm, or death are reported to the local law enforcement agency, the State's Attorney, and to the Child Advocacy Center, as a coordinated approach to the investigations. The approach includes victim sensitive interviewing of the alleged child victim(s) and identification and prosecution for a criminal act. Financial exploitation is not a reportable critical event.

DCFS uses a Child Endangerment Risk Assessment Protocol (CERAP) to assess safety of the child. The interview process includes an assessment of the alleged victim's immediate safety.

A protective plan is enforced in out-of-home settings, such as residential settings. The protective plan restricts accessibility of the alleged perpetrator to the child, and it stays in place until the investigation is completed. If the investigation determines that an abuse or neglect situation is indicated, license revocation or remediation activities begin. Monitoring is conducted weekly by investigators and licensing staff until resolved.

If a finding is indicated, the perpetrator's name is placed on the DCFS State Central Register for a minimum of five years, 20 years if there was serious physical injury, and 50 years in cases of sexual penetration or death. If a finding is unfounded, the name is on the DCFS State Central Register for a minimum of 30 days up to three years depending on the seriousness of the situation.

The MA and the OA will work with the Department of Children and Family Services (DCFS) to develop a relationship and strategies on sharing information in order to improve remediation activities with providers serving participants.

In order to further enhance its Incident Reporting Management System, the HFS submitted an Action Plan to CMS with the waiver renewal. The Action Plan outlines the activities that HFS is undertaking to establish a formal process for state level review. The Action Plan has been incorporated into the waiver by reference. The MA and the OA will report the progress of the Quality Improvement Strategy in the annual 372 reports.

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 OA reviews all identified allegations of abuse, neglect, and exploitation; tracks allegations in order to identify trends at an individual, provider, or systemic level; shares individual allegations with the MA as they are received; and prepares monthly summary reports of allegations for trend analysis by both the OA and MA. The MA monitors this activity through the individual and monthly reports.

In addition to the State's review of the allegations reported by the providers, the MA and OA conduct oversight through the following activities.

Participants and their representatives may make complaints directly to the OA. Refer to Appendix F-3-c.

Further, ISSAs, under contract with the OA, identify and address or refer issues to the OA. Refer to Appendix F-3-b.

The OA may directly identify allegations or complaints through its on-site reviews of a representative sample of participants. The MA participates in these reviews as possible.

The Operating Agency maintains a tracking database of reported and otherwise identified incidents and remediation activities. The OA reviews and addresses individual incidents. Summary reports are produced monthly and shared with the MA.

The MA and the OA work together through the Quality Management Committee, which meets quarterly, to identify and discuss trends and possible system improvement strategies. The OA is responsible for remediation activities and implementing systemic improvements.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. Use of Restraints or Seclusion. *(Select one)*:

○ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

◉ **The use of restraints or seclusion 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 or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Illinois outlines its policy in regards to restraints and use of seclusion in 89 Illinois Administrative Code 384. This rule is available upon request from either the Medicaid or Operating Agency or via the State's website at http://www.ilga.gov/commission/jcar/admincode/089/08900384sections.html. As stated in the rule, its purpose is "to explain acceptable behavior treatment techniques and to assure that these techniques are used only under controlled conditions by appropriately trained personnel." It also identifies "limitations and restrictions on specific behavior treatment techniques related to crisis prevention, behavior intervention, and behavior management."

The rule specifies the accepted crisis intervention and behavior management models approved by the State for use in Children's Group Homes. Each of these models incorporates an emphasis on alternatives to the use of restraint and seclusion. Each provider must develop an overall Behavior Treatment Plan, inclusive of a crisis intervention and behavior management model. Staff of providers must be fully trained in the use of the provider's chosen model, including the alternate methods to be used in order to avoid restraint and seclusion.

The service agreement between the Operating Agency and the provider requires that this rule be followed. Specific safeguards contained in the rule include, but are not limited to, the following items:

•The rule specifies the general components of the providers' Behavior Treatment Plan, e.g., a written statement of purpose; the procedures employed and their operational details; the system for collecting, reviewing, and aggregating data; procedures for reporting and handling behavior emergencies.

•It also requires the Behavior Treatment Plan to contain specific information regarding personnel, e.g., a description of credentials of the personnel involved; required training, re-training, and competency assurance; discipline and/or discharge policies.
•The rule requires the Behavior Treatment Plan to contain a quality assurance mechanism that includes a continuing review of the child's medical record and condition, as well as a continuing review of the developmental and psychological condition.
•It also requires a process for reviewing service plans and the use of restraints, including review by a Human Rights Committee.
•It requires policies for informing parents/guardians of restraint policies, advising them of rights, and obtaining consent.
•The rule ensures that each application of manual restraint may be used only as a therapeutic measure when a child presents a threat of physical harm to self or others.
•It states manual restraint shall not be used until after other less restrictive procedures or measures have been explored and found to be inappropriate.
•It provides that manual restraint shall not be used for a child whose medical condition, mental illness, or developmental or psychological status contraindicates the use of this technique, as documented in the child's individual treatment plan.
•The rule further provides for time limits on the use of manual restraint, involvement of professional staff, documentation requirements, and review by the provider's administration.
•The rule states that manual restraint shall be employed only by persons who are certified as having successfully completed a competency based training program—approved by the Child Welfare Agency—presenting the specific procedures to be used.
•The rule contains language regarding seclusion similar to all the dot points listed above for manual restraints.
•The rule prohibits the use of chemical and/or mechanical restraints.

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

Three State agencies are involved in the oversight of the use of restraint and seclusion in Children's Group Homes: the Medicaid Agency, the Operating Agency, and the Child Welfare Agency (the Department of Children and Family Services).

Per 89 Illinois Administrative Code 384, providers of Children's Group Home services are required to report unusual incidents regarding discipline and behavior management to the Child Welfare Agency as follows:

•The facility shall report as an unusual incident:
o Any injury received by a child as a result of discipline or behavior management;
o Any 30-day period in which five or more instances of restraint and/or confinement of a specific child occurred;
o Any violation of 89 Illinois Administrative Code 384. (Any violation of Rule 384 is considered by the Operating Agency to be an unauthorized use of restraint, seclusion, or restrictive interventions.)
•Reports shall be made in writing and postmarked within two business days after the unusual incident.

Upon receipt and review of a report, should the Child Welfare Agency consider it to include a potential abuse or neglect situation, the Child Welfare Agency is responsible for investigating the matter as potential abuse or neglect. In the event it considers the participant to be at risk, the Child Welfare Agency will immediately require necessary steps to ensure the participant's safety, e.g., requiring staff to be removed from direct contact with participants. None of these actions, including required reporting under this rule, change the provider's responsibility to report all allegations of abuse or neglect or the Child Welfare Agency's responsibility to investigate allegations of abuse or neglect. These responsibilities are described in Appendix G-1.

The Operating Agency requires the reports of the unusual incidents described above (i.e., incidents resulting in injury, more than five incidents in a 30-day period, and any unauthorized use) to be reported to it by facsimile or electronic means by the end of the business day following the day of the incident. The Operating Agency shares these reports with the Medicaid Agency within the first business day of receipt. The reports are tracked on a referral database by the Operating Agency. Reports from this database will be shared with the Medicaid Agency on a monthly basis. The reports will summarize information by type of incident, provider, and action taken.

In addition to the above reports, the following activities provide opportunities for discovery of compliance with 89 Illinois Administrative Code 384 and the unauthorized use of restraint or seclusion:

•The Child Welfare Agency licenses the Children's Group Home providers. (See Appendix C.) As part of this licensure activity, it reviews restraint and seclusion issues. Copies of the reports of the licensure reviews are shared with the Operating and Medicaid Agencies.
•The Operating Agency, using a representative sample of Waiver participants on an annual basis, reviews the use of restraints and seclusion through on-site record reviews, interviews, and observations. The on-site reviews include required reporting within the timelines to the Child Welfare agency. The Medicaid Agency participates in all on-site

reviews as possible.
•The Operating Agency annually surveys participants' families/guardians, using the same representative sample, regarding the use of restraints and seclusion.
•The ISSAs, under contract with the Operating Agency, review restraint and seclusion issues for every Waiver participant during their quarterly monitoring activities. ISSAs are mandated reporters and are thus required to report to the Child Welfare Agency any allegations of abuse or neglect. In addition, they are required through their contracts to report to the Operating Agency any issues with the provider regarding unauthorized use of restraint or seclusion.

The Operating Agency uses all of the above sources of information to review reports, ensure remediation is completed, and track trends. Appropriate remediation activity may include corrective action plans, re-training of staff, increased monitoring, systemic procedural modifications, etc. The Operating Agency also aggregates data and identifies trends from these sources, developing evidentiary reports for review and analysis by the Quality Management Committee during its quarterly meetings. The evidentiary reports summarize remediation timelines as follows: within 30 days, between 31 and 60 days, more than 60 days, and outstanding. The Operating Agency may impose sanctions if necessary to ensure remediation.

The Medicaid Agency monitors these activities by reviewing incident reports as they are received, by participating with the Operating Agency in on-site reviews, and by reviewing and analyzing monthly incident reports and evidentiary reports through its participation in the quarterly Quality Management Committee meetings.

To improve reports and monitoring of unusual incidents in Child Group Homes, the Operating Agency is developing a process that will require reports of unusual incidents within a prescribed time frame. The State will follow the time lines reflected in the action plan.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

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 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.

In addition to the restraint/seclusion issues discussed in G-2.a.i., 89 Illinois Administrative Code 384 also addresses the use of discipline.

Discipline is defined as providing specific consequences for infractions of the rules of a group home as a means of helping children both to develop self-control and to learn they are responsible for their actions. It is to be used only as a last resort after non-aversive methods have been employed. Disciplinary issues are reviewed by the team on an annual basis, at a minimum.

The rule provides examples of acceptable discipline, including assigning special or additional tasks not to exceed one month; temporarily removing privileges for periods not to exceed one month; withholding a child's personal spending money, for purposes and within limitations specified in the rule; and restricting the child to the room (not to exceed three hours with reasonable supervision) or premises (not to exceed three days).

The rule also prohibits certain actions including, but not limited to, subjecting participants to discipline that is out of proportion to the particular inappropriate behavior or is more than 24 hours after the provider learned of the behavior; subjecting the participant to verbal abuse, threats, or derogatory remarks; using corporal punishment under any circumstances; depriving the participant of food, visits or phone calls with family and professionals, clothing (unless otherwise indicated for clinical or safety reasons), sleep, or exercise; assigning exercise; forcing the participant to take

an uncomfortable position; assigning strenuous or harsh work or work that is beyond the capacity of the participant; disciplining for toilet accidents; or depriving the participant of educational services.

Each group home shall have simple, understandable rules for both children and staff. The rules shall be explained and given to each participant at the time of enrollment. Each staff member shall receive training in the rules of the group home and shall be given a written copy of the rules prior to starting active service.

With respect to acceptable discipline, as described in subsections (e)(1) through (e)(5) of the rule:
• Prior to the application of the discipline, the child shall be informed of the rule infraction;
• Prior to application of the discipline, the reasons for the nature of, and duration of the discipline shall be explain to the child;
• The case record shall contain documentation of the discipline applied, specifying the conduct of the child leading to the discipline and the nature and duration of the discipline, and
• The administrator of the facility or designee shall review discipline applied to individual children within 48 hours after administration of the discipline. The reviewer shall not be the individual who imposed the disciplinary measure. The administrator of the group home or designee shall approve or disapprove of the discipline imposed and shall indicate review and approval/disapproval by signing and dating the report of discipline. If the administrator or designee disapproves of the discipline imposed, the administrator or designee shall state the reasons for disapproval and shall correct the use of improper disciplinary techniques.

The OA reviews these issues during on-site reviews through its representative sample of Waiver participants. The MA participates in these reviews as possible. Data, including remediation activity, is collected, aggregated, and analyzed by both the MA and OA under one of the performance measures in Appendix G: The number and percent of restraint applications, seclusion, or other restrictive interventions that did not follow procedures as specified in the approved waiver. The OA is responsible for remediation activities.

To ensure appropriate remediation, the OA reviews the issues and identifies the most appropriate response on an individual basis, including time lines for remediation. Remediation would include immediate action if warranted or referral to DCFS if a potential licensure violation is involved. General responses may include work with participants and their providers, retraining staff, technical assistance, increased monitoring, revising service plans, and requiring plans of correction. The OA is responsible for seeing that these individual issues are resolved. The OA provides quarterly reports of these activities to the MA. Staff of the two State agencies review the reports on a quarterly basis.

In order to further enhance its Incident Reporting Management System, the HFS submitted an Action Plan to CMS with the waiver renewal. The Action Plan outlines the activities that HFS is undertaking to establish a formal process for state level review. The Action Plan has been incorporated into the waiver by reference. The MA and OA will inform CMS of progress in the annual 372 reports and provide quarterly status reports to the Regional Office until implementation occurs on an on-going basis until completed.

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:

Three State agencies are involved in the oversight of the use of restrictive interventions in Children's Group Homes: the Medicaid Agency, the Operating Agency, and the Child Welfare Agency (the Department of Children and Family Services).

Per 89 Illinois Administrative Code 384, providers of Children's Group Home services are required to report unusual incidents regarding discipline and behavior management to the Child Welfare Agency as follows:

•The facility shall report as an unusual incident:
oAny injury received by a child as a result of discipline or behavior management;
oAny 30-day period in which five or more instances of restraint and/or confinement of a specific child occurred;
oAny violation of 89 Illinois Administrative Code 384. (Any violation of Rule 384 is considered by the Operating Agency to be an unauthorized use of restraint, seclusion, or restrictive interventions.)

•Reports shall be made in writing and postmarked within two business days after the unusual incident.

Upon receipt and review of a report, should the Child Welfare Agency consider it to include a potential abuse or neglect situation, the Child Welfare Agency is responsible for investigating the matter as potential abuse or neglect. In the event it considers the participant to be at risk, the Child Welfare Agency will immediately require necessary steps to ensure the participant's safety, e.g., requiring staff to be removed from direct contact with participants. None of these actions, including required reporting under this rule, change the provider's responsibility to report all allegations of abuse or neglect or the Child Welfare Agency's responsibility to investigate allegations of abuse or neglect. These responsibilities are described in Appendix G-1.

The Operating Agency requires the reports of the unusual incidents described above (i.e., restraints resulting in injury, more than five incidents in a 30-day period, and any unauthorized use) to be reported to it by facsimile or electronic

means by the end of the business day following the day of the incident. The Operating Agency shares these reports with the Medicaid Agency within the first business day of receipt. The reports are tracked on a referral database by the Operating Agency. Reports from this database will be shared with the Medicaid Agency on a monthly basis. The reports will summarize information by type of incident, provider, and action taken.

In addition to the above reports, the following activities provide opportunities for discovery of unauthorized restrictive interventions:

•The Child Welfare Agency licenses the Children's Group Home providers. (See Appendix C.) As part of this licensure activity, it reviews the use of discipline. Copies of the reports of the licensure reviews are shared with the Operating and Medicaid Agencies.
•The Operating Agency, using a representative sample of Waiver participants on an annual basis, reviews the use of restrictive interventions through on-site record reviews, interviews, and observations. The on-site reviews include required reporting within the timelines to the Child Welfare agency. The Medicaid Agency participates in all on-site reviews as possible.
•The Operating Agency annually surveys participants' families/guardians, using the same representative sample, regarding restrictive intervention issues.
•The ISSAs, under contract with the Operating Agency, review restrictive intervention issues for every waiver participant during their quarterly monitoring activities. ISSAs are mandated reporters and are thus required to report to the Child Welfare Agency any allegations of abuse or neglect. In addition, they are required through their contracts to report to the Operating Agency any issues with the provider regarding unauthorized use of restrictions.

The Operating Agency uses all of the above sources of information to review reports, ensure remediation is completed, and track trends. Appropriate remediation activity may include corrective action plans, re-training of staff, increased monitoring, systemic procedural modifications, etc. The Operating Agency also aggregates data and identifies trends from these sources, developing evidentiary reports for review and analysis by the Quality Management Committee during its quarterly meetings. The evidentiary reports summarize remediation timelines as follows: within 30 days, between 31 and 60 days, more than 60 days, and outstanding. The Operating Agency may impose sanctions if necessary to ensure remediation.

The Medicaid Agency monitors these activities by reviewing reports as they are received, by participating with the Operating Agency in on-site reviews, and by reviewing and analyzing monthly incident reports and evidentiary reports through its participation in the quarterly Quality Management Committee meetings.

To improve reports and monitoring of unusual incidents in Child Group Homes, the Operating Agency is developing a process that will require reports of unusual incidents within a prescribed time frame. The State will follow the time lines reflected in the action plan.

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.

Child Group Home provider licensure standards require that participants receive medical and dental examinations annually or more frequently if needed. Diagnosed medical problems and dental defects must be treated promptly. They also require written consents from the legally responsible parent or guardian for medical treatment, including medication administration. Providers must maintain a written record of special medical and dental needs of each participant and a written record of all medications prescribed and administered.

The Operating Agency and the Department of Children and Family Services are responsible for oversight of medication

management issues. Registered nurses, employed by or under contract with the Operating Agency, review compliance with Administrative Rule 116 (Medication Management) in a sample of Child Group Homes that use non-licensed staff to administer medications.

The OA and MA review team includes Registered Nurses. The team reviews participant medication regimen and compliance with rules applicable to medication use and administration. A representative sample of participants is reviewed annually.

Providers must have a quality assurance committee to review the use of psychotropic medications. Additional information regarding medication management is provided in b-ii and c-ii below.

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.

Child Group Home providers have ongoing responsibility for monitoring participant medication regimens. Participant medications are managed in the group homes as follows:

• A physician must be responsible for the medical services provided to participants, and the management of participants' medications.

• The qualified mental retardation professional must ensure employees, guardians, and waiver participants have information on expected consequences, potential benefits, and side effects of any prescribed medication.

• Informed consent must be obtained from the participant or guardian for all medical services and medications arranged by the provider.

• A competent medical professional must review the medications prescribed and must see the participant at least annually, and every three months if psychotropic medications, or any medications to manage behavior, have been prescribed. Physician documentation within the individual record must include, but is not limited to, the rationale for continuing current medications at current levels and/or initiating new medications; and medication side effects.

• A competent medical professional must perform an examination of the participant prior to the initiation of psychotropic medications or any medications to manage behavior.

• A psychiatrist must be available for consultation when psychotropic medications have been prescribed.

• Screening for and documentation of abnormal involuntary movements, including tardive dyskinesia, in participants receiving prescribed psychotropics for which this is indicated as a possible side effect, must be completed at least every six months by employees trained in performing this type of assessment.

The provider is responsible to report medication errors to the OA.

The OA and MA review team includes Registered Nurses. The team reviews participant medication regimen and compliance with rules applicable to medication management and administration. A representative sample of participants is reviewed annually. Participant-specific issues are followed up as part of the review process. The Operating Agency is responsible for oversight and follow-up of medication management issues.

Potentially harmful medication management practices identified in the course of the reviews are brought to the Quality Management Committee, which includes the MA and meets quarterly, for discussion of appropriate systemic follow-up action. DCFS is a member of the Committee as they are the licensing authority for the residential provider (child group home) in the children's residential waiver.

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 Child Group Home 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). The provider 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 (Rule 116).

Child Group Home providers have ongoing responsibility for monitoring participant medication regimens and ensuring compliance with the Illinois Nursing and Advanced Practice Nursing Act (225 ILSC 65) and Rule 116. Providers must maintain and implement written policies and procedures that include provisions describing on-going supervision and monitoring of direct support staff who are authorized to administer medications, annual review and any necessary retraining of authorized direct support staff in the theory and practice of medication administration, a systematic review of all medication errors, adverse drug reactions, and incidents to identify contributing factors and plan corrective action, recording and reporting of all instances of retraining and retesting for failure to qualify as an authorized direct support staff.

Rule 116 permits a registered nurse who has successfully completed the OA/DHS approved nurse-trainer course for medication administration in the community (6 hours) to authorize direct support personnel to administer medication in residential sites.

Medication training programs for authorized staff must be implemented and carried out only by a registered professional nurse and may not be carried out by direct support staff or other unauthorized personnel.

Authorized direct support personnel must be at least 18, have completed high school or G.E.D., demonstrate functional literacy, and have successfully completed required competency-based training and assessment by the nurse-trainer. Training includes specifics related to the participant, medication, dosages, etc. Direct support personnel are authorized to administer only those specific medications to specific participants for which they have successfully completed training and competency evaluations. Authorized direct support personnel are re-evaluated by a nurse-trainer at least annually to ensure competency to administer each medication to each participant.

The Child Group Home provider must ensure and document the following:
• Only a competent medical professional, that is, a physician licensed pursuant to the Medical Practice Act, advanced practice nurse licensed pursuant to the Nursing and Advanced Practice Nursing Act, and physician's assistant licensed pursuant to Physician Assistant's Practice Act, may prescribe and monitor all prescription medications.

• All medications, including patent or proprietary medication, e.g., cathartics, headache remedies, or vitamins, may be given only upon the written order of a competent medical professional. Rubber stamp signatures are not acceptable. All orders must be given as prescribed by the competent medical professional and at the designated time. A registered professional nurse or licensed practical nurse may take telephone orders. All orders must be immediately signed by the nurse taking the order and placed in the participant's record. These orders must be countersigned or documented by facsimile prescription by the competent medical professional within ten working days.

• An individual medication administration record (MAR) must be kept for each participant for medication administered. It must contain at least the following:
-- the participant's name;
-- the name and dosage form of the drug;
-- the name of the prescribing physician, physician assistant,
advanced practice nurse, dentist, podiatrist, or certified
optometrist;
-- dose;
-- frequency or times of administration;
-- route of administration;
-- date and time given;
-- most recent date of the order;
-- allergies to medication; and
-- special considerations.

•The MAR for the current month must be kept with the medications or in the 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.

•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.

• 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 Operating Agency approved screening and assessment tools, in accordance with Rule 116.

• When agencies supervise the self-administration of medication training programs or administer the medications, medications must be secured from unauthorized access and only a physician, pharmacist, registered or licensed practical nurse or agency employee authorized to supervise the self-administration of medication training program or administer medications may have access to medications. A physician, pharmacist or registered professional nurse must be available at all times to consult with trained, unlicensed direct support employees administering medications or supervising a self-administration of medications training program for persons with developmental disabilities.

•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.

• Participants who are able to self-administer medications independently must have access to their medications.

• All medications must be labeled.

• Medications must be stored safely and at appropriate temperatures.

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:

  Child Group Home providers must report medication errors to the Operating Agency, the Department of Human Services. The OA will select a sample of providers for review each quarter.

  (b) Specify the types of medication errors that providers are required to *record:*

  Child Group Home providers are required to record all medication errors.

  (c) Specify the types of medication errors that providers must *report* to the State:

  Child Group Home providers are required to report all medication errors quarterly in a summary report format to the Operating Agency.

  Any medication error that results in an adverse outcome is to be reported by fax to the Operating Agency within 7 days of discovery.
- ( ) **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Operating Agency and the Department of Children and Family Services (DCFS) are responsible for oversight and follow-up of medication administration issues.

DCFS annual licensure visits and routine unannounced staff monitoring visits include a review of the medication logs.

The OA and MA review and observe medication administration and training records during annual quality assurance reviews of Child Group Home providers. The review teams include Registered Nurses. A representative sample of participants is reviewed annually. In the event that any significant issues are noted, the OA would return for follow-up. Participant-specific issues are followed up as part of the review process.

The results of the quality assurance reviews including medication management are reviewed with the Quality Management Committee, which meets quarterly and includes the Medicaid Agency. The Department of Children and Family Services participates in the Committee as needed for children's residential waiver.

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, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
The number and percent of participant records reviewed where the participant (and/or family or legal guardian) received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved waiver.

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:
The number and percent of participants (and/or family or legal guardian) reporting they received information/education about how to report abuse, neglect, exploitation and other critical incidents as determined by the state.

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:
Number and percent of participants for whom identified critical incidents were reviewed and appropriate measures taken by the provider.

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:
The number and percent of participant deaths reviewed and appropriate measures taken.

Data Source (Select one):
Mortality reviews
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:
The number and percent of restraint applications, seclusion, or other restrictive interventions that did not follow procedures as specified in the approved waiver.

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:
The number and percentage of participants who received the coordination and support to access healthcare services identified in their service plan.

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:
Number and percent of family/guardian survey respondents who reported that staff providing services and supports are respectful and courteous.

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:
Number and percent of family/guardian survey respondents who are satisfied with the way that complaints/grievances regarding providers are handled and resolved.

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:
Number and percent of family/guardian survey respondents who report that their child has access to needed health care services.

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**	☑ **Annually**

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

Performance Measure:
Number and percent of family/guardian survey respondents who report that their child has access to needed dental services.

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:
Number and percent of family/guardian survey respondents who report that service providers have hit or hurt the child.

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:
Number and percent of family/guardian survey respondents who report that service providers have yelled or screamed at the child.

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

each that applies):	*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:
Number and percent of family/guardian survey respondents who report that they feel their child is safe when under the care of service providers.

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:

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.

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 reviews the issues and identifies the most appropriate response. General responses may include work with participants and their providers, retraining staff, voiding claims, technical assistance, increased monitoring, revising service plans, and requiring plans of correction. The OA is responsible for seeing that these individual issues are resolved. The OA provides quarterly reports of these activities to the MA. Staff of the two State agencies review the reports on a quarterly basis.

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 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.
  Refer to G-1.b. and G-1.e.

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 QMS 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 QMS* 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 QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

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 Children's Residential waiver quality management plan is part of an overall quality management plan for the three 1915 (c) HCBS waivers operated by the OA. The other waivers include the Adults with developmental disabilities waiver, (0350) and the Support Waiver for children and young adults (0464). While some data may be collected during the same onsite provider review, the sample for each waiver is independently selected and collected for later trending and aggregation. The samples are drawn separately and the results aggregated separately.

A representative sample is selected by the Operating Agency at the beginning of the waiver year. Reviews are then scheduled and conducted throughout the year. Each performance measure in the application specifies the frequency of data collection and data aggregation. Data collection is continuous and ongoing throughout the year and individual problems are remediated as they are identified. All data collected including the timeliness of remediation activities is summarized quarterly and shared with the Quality Management Committee which meets quarterly. The data is analyzed and evaluated for trends on a quarterly and annual basis. As trends are identified, proactive remediation is initiated. For each trend identified, the State establishes remediation plans by identifying the responsibilities of the Medicaid and Operating Agencies and identifying timeframes for completion. The Quality Management Committee collectively tracks the remediation activity. Annual reports are produced with trends identified based on the full representative sample and/or 100% review of data.

The front line of the quality assurance system is the ISSAs who are employed by the ISC entities under contract with the OA. They visit each waiver participant quarterly to check on their general health and well-being. The ISSAs use a standard tool and protocol that includes such areas as physical environment, individual rights, health, service plan implementation and behavioral supports. A sample of the completed tools for each ISSA is reviewed on an annual basis by the OA during annual ISC reviews. The ISSAs must be independent of any direct care providers and are charged with identifying issues and initiating problem resolution as needed. In the event issues cannot be resolved at the local level, the ISSA must refer the situation to the Operating Agency. The ISSAs are provided with a standardized form for these referrals. The OA tracks such reports and follow up activity in a central referral database. Summary and analytical reports are completed and reviewed by the State's Quality Management Committee for trend identification and system improvement. The MA actively participates in this committee and its reviews and recommendations. Additional information regarding the Medicaid Agency is provided below.

1. Level of Care
•The OA reviews all authorization requests for waiver services to ensure that the applicant has been accurately determined eligible for an ICF/MR level of care by the independent entities. During the initial process, QMRPs and other clinical staff, for example a physician, clinical psychologist, or nurse employed by the Operating Agency, provide further review of the LOC determinations, as needed.
•The ISC entities are surveyed annually by the OA for contract compliance. For these reviews, a sample of individual records is drawn from each of the contracted entities. Surveyors record their findings on a standard tool. The data collected for each of the contracted entities is compiled and summarized via an electronic report.
• State staff reviews system performance at least annually through an analysis of progress or regression in the scope of overall findings and of findings by agency. This typically occurs as part of the annual 372 report process and during routine Quality Management Committee meetings.
•The MA and OA review LOC eligibility and timeliness of redeterminations for a representative sample of participants during residential provider onsite reviews.
•The State's Quality Management Committee reviews summary reports of survey findings and recommends corrective action. Corrective action can include training or technical assistance.

2. Support Plan
•Annually the OA surveys ISSA providers to review individual support plans based on a representative sample of participants to ensure plans are based on adequate assessments, address the participant's needs and are completed on a timely basis.
•When support plan inadequacies are found, the OA takes remedial actions, which include notification of deficiencies and,

a plan of correction, if warranted. Systemic actions may include policy or rule changes, clarifications, technical assistance and training.
•The OA reviews informed choice as a component of the annual review of the ISC agencies for compliance with the contractual agreements.
•The ISSA is a participant in the support planning team. When issues involving the support plans or choice cannot be resolved locally, the ISSA refers individual issues to the OA for technical assistance and follow-up actions as necessary.
•The OA maintains a database to track referrals and follow-up actions.
• Annually Child Group Home providers are monitored by the OA and MA based on a representative sample to ensure that individual support plans comply with contractual and waiver requirements. The review includes the assurances for service plan development, updates, timeliness and implementation for a representative random sample of participants.
•The OA and MA review through a representative sample of participants that participants were given informed choice of waiver services and service providers during the residential onsite reviews.
•Summary reports regarding support plans are reviewed by the State's Quality Management Committee for identification of concerns, patterns and trends and for development of suggestions for improvements. Selected reports are shared with the Statewide Advisory Council. The Quality Management Committee summarizes each meeting, maintains a log of suggestions for improvement, and tracks the implementation of the suggestions.

3. Qualified Providers
•The Department of Children and Family Services conducts focused surveys of the group homes annually and licensure surveys every four years to ensure that licensure requirements are met. The MA and OA review copies of the licensure reports.

• The MA and OA review provider qualifications and training for direct service persons and QSPs (QMRP) serving the participants.
•Summary reports of provider qualification reviews are reviewed by the State's Quality Management Committee for identification of concerns, patterns and trends and for development of suggestions for improvements. Selected reports are shared with the Statewide Advisory Council.

4. Health and Welfare
•ISSAs continuously monitor the waiver participant's health, safety and welfare during their required quarterly visits, or more often as needed. The ISSAs refer individual issues that cannot be resolved locally to the OA for technical assistance and follow-up actions as necessary.
• The OA maintains a database to track referrals and follow-up action.
•The OA issues written communications on health and safety policies and procedures.
•The OA provides training on issues where trends and patterns appear to be systemic.
•The MA and OA review health and welfare provisions through a representative sample of participants during the residential provider onsite reviews. The reviews include visits to the residential sites and interviews with guardians and participants and staff.
•The OA and MA review of Child Group Home and the OA reviews of ISSA providers includes verification that staff have been adequately trained in the reporting of allegations of abuse, neglect and exploitation to the appropriate authority.
•Summary reports of health and welfare findings are reviewed by the State's Quality Management Committee for identification of concerns, patterns and trends and for development of suggestions for improvements. Selected reports are shared with the Statewide Advisory Council.

5. Administrative Oversight
•The Medicaid Agency has an interagency agreement with the OA.
• The OA has ongoing communication with the MA on issues involving program monitoring; testing and monitoring of claims; participation in training; discussion of policy and system changes; and approval of policy changes through the Medical Policy Review System.
•The MA conducts waiver appeal hearings and makes the final decision on all appeals.
•The MA participates onsite with the OA in conducting comprehensive program monitoring of agency providers and participants. The monitoring protocol includes a review of all waiver services and supports that impact the participant.
•Staff from the MA participate in quarterly Quality Management Committee meetings with OA staff. Issues discussed include quality and financial review findings and follow-up activities, quality management planning, and rules, policy and system changes.

6. Financial Accountability
Financial oversight of claims is delegated to the OA to insure that they are coded and paid in accordance with the reimbursement methodology specified in the approved waiver.

The OA conducts post payment reviews of claims based on the sampling specified in Appendix I.

The OA submits a quarterly report to the MA with their findings and remediation activities. The Medicaid Agency conducts a validation review based on the OA report of post-payment activities to verify procedures were followed and that appropriate remediation activities were taken.
•The QA reports are discussed within the Quality Management Committee, issues are identified, and suggestions for

improvements are made. The Quality Management Committee summarizes each meeting, maintains a log of suggestions for improvement, and tracks the implementation of the suggestions.

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 OA compiles results of all review activity to identify trends and presents these findings with the MA. Based on identified patterns of concerns, corrective action is initiated by the OA to address and prevent similar problems with other providers. Such action is dependent on the specific identified issue but may include revision of training curricula, issuance of clarification memos, revision of contract language, and/or modification of performance measures.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The process to evaluate the State's Quality Improvement Strategy is conducted annually as part of the Quality Management Committee activities. A portion of one meeting per year will be devoted to an overview of the previous year's activities and whether changes are needed to the Quality Management Committee procedures, membership and scope.

On a quarterly basis, key staff from the MA Bureau of Interagency Coordination meet with key staff from the OA to review all Performance Measures and remediation activities. Summarized evidentiary data are reviewed, trends are identified and additional remediation activities are developed and incorporated into the Quality Improvement Strategy. Meeting summaries of the Quality Management Committee track remediation activities and outcomes that are incorporated into the State's Quality Improvement Strategy.

On a quarterly basis the OA will share the data collected in the previous quarter on performance measures identified in the Waiver. Findings or trends identified to date will be discussed. Changes to the QIS will be recommended based on identified trends.

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).

Providers 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 in a consolidated financial report form prescribed by the Operating Agency, regardless of overall funding level.

This independent audit is an Operating Agency requirement and the Single Audit Act of 1984 (Act) and the Single Audit Act Amendment of 1996 does not apply to this Waiver. Medicaid payments received as reimbursement for providing services to

Medicaid eligible individuals are not considered Federal awards under the Act and therefore, providers are exempt from Federal audit requirements for these payments.

Individual providers and businesses that are not under contract with the Operating Agency are not required to have audits done 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 annually conducts desk reviews and a sample of on-site audit reviews of required independent audits on an annual basis.

The Medicaid and Operating Agencies work cooperatively to review rates and provider claims. The MA delegates the oversight of claims to the OA. The OA ensures that claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver.

The OA will review 100% of claims verifying the following:

1)The individual was eligible and enrolled in the waiver on the date of service, and,

2)The rates were paid in accordance with the reimbursement methodology.

In addition, the OA will select a representative sample of participant claims and conduct post-payment reviews to verify that services were approved in the participant's service plan.

The OA will summarize the data and provide quarterly reports to the MA of their findings and any remediation activities (on an individual and systemic basis). Remediation activities may include, recommending that the OA clarify policy, retrain staff, provide technical assistance, void claims, increase monitoring, conduct focused reviews with the MA, or develop plans of correction, as appropriate.

The Medicaid Agency will perform a validation review to verify that the OA report to verify that post-payment review procedures were followed and appropriate corrective actions were taken.

The MA's validation review will include an assessment and review of the internal controls established by the OA for their post-payment review process. The MA will assess the appropriateness of established controls and perform tests to provide reasonable assurance that the established controls were followed. The MA will use the data warehouse to verify that claiming errors were corrected by crediting CMS with any applicable FFP. As a result of the validation review, the MA will work with the OA to modify and strengthen internal controls as needed.

The Operating Agency reviews rate calculations anytime there is a significant change in the computerized information management system. The Medicaid agency also reviews the residential rate components calculated by the Operating Agency for accuracy and validity whenever residential providers receive a rate increase. Although the room and board component of a residential rate is not claimed for FFP, it is still an integral factor in the calculation of a residential rate and is included in the Medicaid Agency review.

The results of all financial reviews and remediation activities are shared between the two State Agencies and discussed during the Quality Management Committee meetings. In addition, results of some reviews may be shared with the Statewide Advisory Council on Developmental Disabilities in order to obtain input from stakeholders regarding corrective actions.

Appendix I: 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.
   i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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:
Number and percent of waiver claims reviewed that were submitted using the correct rate as specified in the waiver application.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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 =
☐ **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:
Number and percent of waiver service claims reviewed that were submitted for participants who were enrolled in the waiver on the date that the service was delivered.

Data Source (Select one):
Other

If 'Other' is selected, specify:
Comparison of claims with enrollment data or 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:
Number and percent of reviewed waiver service claims submitted for FFP that are specified in the participant's service plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Comparison of claims submitted for FFP with service plans

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.

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 reviews the issues and identifies the most appropriate response. General responses may include work with participants and their providers, retraining staff, voiding claims, technical assistance, increased monitoring, revising service plans, and requiring plans of correction. The OA is responsible for seeing that these individual issues are resolved. The OA provides quarterly reports of these activities to the MA. Staff of the two State agencies review the reports on a quarterly basis.

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.

Residential Habilitation
Child Group Home rates are calculated based on a joint rate methodology shared by the Operating Agency and the Department of Children and Family Services. Providers are required to submit annual cost reports. Rates have been subject to cost of living adjustments when enacted and may be adjusted based on rate appeals.

Adaptive Equipment and Assistive Technology
Rates are usual and customary. Payments are subject to prior approval by the Operating Agency. Two bids are required for this approval. There are per-participant five-year cost limits governing the use of these services.

Behavior Intervention and Treatment
There are two rate levels for this service based on provider qualifications. The higher rate is based on a weighted combination of Bureau of Labor Statistics wage for licensed clinical psychologists, provider survey results and a comparison to bargaining agreement wages for state employees. The lower rate is set at 80% of the higher rate. Both rates are subject to cost of living adjustments when enacted.

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, the Operating Agency mails a listing of all covered services and corresponding rates is made available to families, 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 and a dedicated fund

for developmental disability services. The Operating Agency (DHS) maintains a computerized payment system that includes authorization for each participant, payments to providers, units of service delivered to each eligible 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-9-06) between the provider, the Operating Agency and the Medicaid Agency. This agreement contains language that the provider voluntarily reassigns payment to the Operating Agency (DHS). Copies of the 1413A will be on file with the Medicaid Agency.

If a provider chooses not to assign payment to the Operating Agency, the provider will sign the standard Medicaid provider agreement (HFS-1413). The Medicaid Agency will then pay that provider directly. The Operating Agency notifies providers of this option through the Waiver provider manual.

Operating Agency Claims Processing

Information from the Operating Agency computerized payment system then feeds into the computerized claiming system that contains edits to ensure that the participant has been determined to meet the ICF/MR level of care prior to the date of service. The Operating Agency claiming system picks up the established claiming rate and compares it with the actual payment rate; the lower of the two is the amount claimed. For residential services, the established claiming rate is the maximum claiming rate approved by the Operating Agency based on program components of the rate (excluding room and board). For residential services, the Operating Agency's actual payment rate is sometimes less than the established claiming rate, depending on the participant's ability to pay toward the cost of care. Finally, the Operating Agency claiming system subtracts from the Waiver claim the spenddown obligation of each participant, if any (available on a monthly extract from the Medicaid Agency MMIS system).

Medicaid Agency Claims Processing

The Operating Agency Waiver claiming data are transmitted to the Medicaid Agency via computer tape exchange. The Waiver subsection of the MMIS matches the participant against the recipient eligibility file to ensure Medicaid eligibility on the date of service and matches the provider against the provider enrollment file to ensure that the provider is enrolled as a Waiver provider with the Medicaid Agency. The Waiver subsection also ensures the service is covered under the Waiver. The MA MMIS edits the Waiver claims for hospital and LTC claims that are duplicative. The MA deposits the Federal Financial Participation (FFP) associated with this Waiver into a dedicated fund to be used by the Operating Agency for developmental disability services.

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 (DHS) to verify the effective date of each Waiver service authorized in the participant support plan and the participant's level of care eligibility. Providers are required to certify billings are true and accurate.

Provider billings are further validated by applying MMIS processing edits and by conducting Medicaid Agency (HFS) and Operating Agency (DHS) post-payment financial reviews. See also Appendix I-1 for additional information on post-payment reviews.

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, support plan authorization, documentation of service delivery, and computerized payment and claiming systems cross-matched with the Medicaid Agency, MMIS system.

- ○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

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.**
- [x] **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 will make payments directly to providers of Waiver services. The Operating Agency will then send claims based on these paid services electronically to the Medicaid Agency for further adjudication and Federal waiver reimbursement purposes.

The Operating Agency notifies providers of the option to bill the Medicaid Agency directly through the Waiver provider manual.

The MA will conduct a sample review of the findings from the reports and verify that the OA followed their post payment review procedures and verify that appropriate and timely remediation activities were taken.

The Operating Agency 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 100% of claims to determine the following: 1) whether the individual was eligible on the date of services; and 2) whether the rates are in accordance with the reimbursement methodology. The OA submits a quarterly report to the MA with their findings and remediation activities. The Medicaid Agency conducts a validation review based on the report to verify that the OA followed their post-payment review procedures and verifies that appropriate remediation activities were taken. These reports are reviewed during Quality Management Committee meetings and evaluated for trends, patterns, and proactive remediation.

- [ ] **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: *Complete item I-3-e.*

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 pays the providers directly.

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 Fund to the OA. 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 payment rates for Child Group Home providers based on a methodology that is comprised of the following components:
• Room and Board Component - reimburses community providers for keeping a home in normal operation. This component is not claimed for Federal reimbursement.
• 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 school 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.
The Operating Agency sets waiver claiming rates for residential services based on the Program, Transportation and Administration components of the payment rates. The Room and Board Component is excluded in calculating Waiver claiming rates.

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-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: ICF/MR

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	57387.00	6523.14	63910.14	86043.01	3664.07	89707.08	25796.94
2	57387.00	6523.14	63910.14	90199.39	3714.11	93913.50	30003.36
3	57387.00	6523.14	63910.14	94556.54	3764.84	98321.38	34411.24
4	57387.00	6523.14	63910.14	99124.18	3816.26	102940.44	39030.30
5	57387.00	6523.14	63910.14	103912.45	3868.38	107780.83	43870.69

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 Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/MR
Year 1	258	258
Year 2	258	258
Year 3	258	258
Year 4	258	258

Year 5	**258**	258

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 individuals who received Waiver Child Group Home services as reported on Year One of the CMS 372 report.

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:

Estimates are based on the current utilization and costs among children enrolled in the Children's Residential Waiver. Factor D is based on analysis of data for FY2008 – FY2010 (estimated) costs for children who received waiver services in a Child Group Home. The 1.77% increase is based upon the historical average percent of change, which is comprised of rate increases and case mix changes for FY2008 – FY2010 (estimated).

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is based on analysis of data for FY2008 – FY2010 (estimated) Medicaid ancilliary costs for children who would be receiving waiver services in a home environment. The 0% increase is based upon the historical average percent of change, which is comprised of rate increases and case mix changes for FY2008 – FY2010 (estimated).

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 upon historical data for FY2008 – FY2010 (estimated) and includes data for all age groups. Factor G estimated for FY2011 – FY2015 is based upon historical percent changes trended forward for all years. The average historical percent change was 4.83%.

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 upon historical Medicaid Ancillary services for those individuals in an ICFMR setting for FY2008 – FY2010 (estimated). The data incorporates individuals of all age groups. Factor G' estimated for FY2011 – FY2015 is based upon historical percent changes trended forward for all years. The average historical percent change was 1.37%.

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
Child Group Home
Adaptive Equipment
Assistive Technology
Behavior Intervention and Treatment

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
Child Group Home Total:						**14706000.00**
Day	Day	258	300.00	190.00	**14706000.00**	
Adaptive Equipment Total:						**6000.00**
Per Item	Per Item	25	2.00	120.00	**6000.00**	
Assistive Technology Total:						**12500.00**
Per Item	Per Item	25	1.00	500.00	**12500.00**	
Behavior Intervention and Treatment Total:						**81250.00**
Hourly	Hour	25	50.00	65.00	**81250.00**	
				GRAND TOTAL:		**14805750.00**
				Total Estimated Unduplicated Participants:		**258**
				Factor D (Divide total by number of participants):		**57387.00**
				Average Length of Stay on the Waiver:		300

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 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 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Child Group Home Total:						**14706000.00**
Day	Day	258	300.00	190.00	**14706000.00**	
Adaptive Equipment Total:						**6000.00**
Per Item	Per Item	25	2.00	120.00	**6000.00**	

Assistive Technology Total:						**12500.00**
Per Item	Per Item	25	1.00	500.00	**12500.00**	
Behavior Intervention and Treatment Total:						**81250.00**
Hourly	Hour	25	50.00	65.00	**81250.00**	
			GRAND TOTAL:			**14805750.00**
			Total Estimated Unduplicated Participants:			**258**
			Factor D (Divide total by number of participants):			**57387.00**
			Average Length of Stay on the Waiver:			300

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
Child Group Home Total:						**14706000.00**
Day	Day	258	300.00	190.00	**14706000.00**	
Adaptive Equipment Total:						**6000.00**
Per Item	Per Item	25	2.00	120.00	**6000.00**	
Assistive Technology Total:						**12500.00**
Per Item	Per Item	25	1.00	500.00	**12500.00**	
Behavior Intervention and Treatment Total:						**81250.00**
Hourly	Hour	25	50.00	65.00	**81250.00**	
			GRAND TOTAL:			**14805750.00**
			Total Estimated Unduplicated Participants:			**258**
			Factor D (Divide total by number of participants):			**57387.00**
			Average Length of Stay on the Waiver:			300

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
Child Group Home Total:						**14706000.00**
Day	Day	258	300.00	190.00	**14706000.00**	
Adaptive Equipment Total:						**6000.00**
Per Item	Per Item	25	2.00	120.00	**6000.00**	
Assistive Technology Total:						**12500.00**
Per Item	Per Item	25	1.00	500.00	**12500.00**	
Behavior Intervention and Treatment Total:						**81250.00**
Hourly	Hour	25	50.00	65.00	**81250.00**	
				GRAND TOTAL:		**14805750.00**
				Total Estimated Unduplicated Participants:		**258**
				Factor D (Divide total by number of participants):		**57387.00**
				Average Length of Stay on the Waiver:		300

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
Child Group Home Total:						**14706000.00**
Day	Day	258	300.00	190.00	**14706000.00**	
Adaptive Equipment Total:						**6000.00**
Per Item	Per Item	25	2.00	120.00	**6000.00**	
Assistive Technology Total:						**12500.00**
Per Item	Per Item	25	1.00	500.00	**12500.00**	
Behavior Intervention and Treatment Total:						**81250.00**
Hourly	Hour	25	50.00	65.00	**81250.00**	
				GRAND TOTAL:		**14805750.00**
				Total Estimated Unduplicated Participants:		**258**
				Factor D (Divide total by number of participants):		**57387.00**
				Average Length of Stay on the Waiver:		300