

## 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		
Other 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

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02011 group living, residential habilitation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include 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  
 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:**

Other Service

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

**Service Title:**

Adaptive Equipment

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Adaptive equipment, as specified in the plan of care, includes (a) devices, controls, or appliances that enable participants to increase or maintain 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 equipment and supplies furnished by the school program or by the State Plan and exclude those items that are not of direct remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. All purchased items shall be the property of the participant or the participant's family.

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

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

To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

**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
- 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: Adaptive Equipment

Provider Category:

Agency

Provider Type:

Equipment Vendor

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Enrolled vendor approved by the waiver case manager and participant/family.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Upon Enrollment

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

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W

Category 3:

Sub-Category 3:

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W

Category 4:

Sub-Category 4:

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W

**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 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 the 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.

To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

**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
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Equipment Vendors

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Assistive Technology

**Provider Category:**

Agency

**Provider Type:**

Equipment Vendors

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Enrolled vendor approved by the waiver case manager and participant/family.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

OA

**Frequency of Verification:**

Upon Enrollment

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

**Service Type:**

Other Service

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

**Service Title:**

Behavior Intervention and Treatment

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

10 Other Mental Health and Behavioral Services  0040 behavior support

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Behavior intervention and treatment includes a variety of individualized, behaviorally-based treatment models consistent with best practice and research on effectiveness that are directly related to 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 QIDP, 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
- 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.

The Provider must be a Medicaid Enrolled Vendor.

**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 Intellectual Disability Professional (QIDP) 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 person-centered service 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 service 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
Adaptive Equipment	<input type="checkbox"/>
Child Group Home	<input checked="" type="checkbox"/>

Waiver Service	Provided in Facility
Behavior Intervention and Treatment	<input checked="" type="checkbox"/>
Assistive Technology	<input type="checkbox"/>

**Facility Capacity Limit:**

10

**Scope of Facility Standards.** 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	<input type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

**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.*

- Self-directed
- Agency-operated

- 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 and their legal representatives, with the assistance of the Individual Service and Support Advocate (ISSA), 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.

Information regarding provider qualifications and program guidelines is continuously available on the Operating Agency's website at <http://www.dhs.state.il.us/page.aspx?item=47336>. This website lists all types of providers within

the developmental disabilities services system, briefly describes what each does, lists requirements and qualifications, links those interested to regulatory documents and forms, and provides contact information.

Potential providers must review the regulatory documents linked to the website. They must also complete the required forms for their provider type and submit them to the contact person listed.

Each provider must complete a Medicaid Provider Enrollment agreement, which is a three-way agreement among the provider, OA, and MA.

**Appendix C: Participant Services**

**Quality Improvement: Qualified Providers**

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

**a. Methods for Discovery: Qualified Providers**

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**CI Number and percent of licensed or certified providers who meet initial licensure/certification standards. N: Number of newly enrolled licensed/certified providers who meet initial licensure/certification standards. Denominator: Total number of newly enrolled licensed/certified providers.**

**Data Source (Select one):**

**Program logs**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

**Performance Measure:**

**C2** Number and percent of licensed or certified providers who continue to meet licensure/certification standards on an ongoing basis. Numerator: Number of licensed/certified providers who continue to meet licensure/certification standards on an ongoing basis. Denominator: Total number of enrolled licensed/certified providers.

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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

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

**Performance Measure:**

**C3 Number and percent of non-licensed/non-certified providers reviewed, by provider type, who meet initial provider qualifications. Numerator: Number of non-licensed/non-certified providers who met initial provider qualifications. Denominator: Total number of newly enrolled non-licensed/non-certified providers.**

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
	<input type="checkbox"/> Other Specify:

**Performance Measure:**

**C4 Number and percent of non-licensed/non-certified providers reviewed, by provider type, who continue to meet waiver provider qualifications. Numerator: Number of non-licensed/non-certified providers who continue to meet qualifications. Denominator: Total number of non-licensed/non-certified providers.**

**Data Source (Select one):**

**Program logs**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: _____

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

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

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

**Performance Measure:**

C5 Number and percent of providers reviewed, by provider type, who meet waiver provider training requirements. Numerator: Number of providers who met training requirements. Denominator: Total number of providers subject to training requirements.

**Data Source (Select one):**

Training verification records

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = _____
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: _____

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: _____
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: _____	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 findings of all quality assurance reviews 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 the findings and remediation 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**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 C: Participant Services

### C-5: Home and Community-Based Settings

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

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

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

See attachment #2