

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

### 1. Major Changes

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Describe any significant changes to the approved waiver that are being made in this renewal application:

This 1915 (c) Residential Services for Children and Young Adults with Developmental Disabilities waiver renewal includes:

1. Inclusion of Performance Measures to be consistent with federal changes in assurances and sub-assurances.
2. Inclusion of language described in our Statewide Transition Plan for Compliance with HCBS settings as required by the Centers for Medicare and Medicaid Services (CMS) and published final regulations that pertain to Home and Community-Based Services (HCBS) programs, including 1915 (c), 1915 (i) and 1915(k) as described in 42 CFR 441.301(c) (4) (5) and 441.710(a) (1) (2). Illinois' Transition Plan was submitted on March 16, 2015 and for this waiver affects primarily services provided in residential settings and specifically to the Child Group Home service.
3. Modifications to processes related to Participant Centered Planning in accordance with same rules described above and enable waiver participants to direct the planning process, include representative(s) whom the individual has freely chosen and results in a person-centered plan with individually identified goals and preferences; defined outcomes in the most integrated community setting, and the delivery of services in a manner that reflects personal preferences and choices and assurances of health and welfare.

In accordance with these substantive changes, this waiver was posted on May 29, 2015 at the website of the Illinois Department of Healthcare and Family Services (HFS),

<http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx>; with public notification on May 29, 2015 in the Illinois Register providing for a minimum of a 30 day feedback period.

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

### 1. Request Information (1 of 3)

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- 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: renewal**

**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.R02.00

**Draft ID:** IL.022.02.00

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

Regular Waiver 

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

07/01/17

**Approved Effective Date:** 07/01/17

## 1. Request Information (2 of 3)

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**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 in 42 CFR §440.160**

**Nursing Facility**

Select applicable level of care

**Nursing Facility as defined in 42 CFR §§440.40 and 42 CFR §§440.155**

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:



**Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

**Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

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



## 1. Request Information (3 of 3)

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**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 Eligibility 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

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**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/IDD. 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, and the waiver program is cost neutral.

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

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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

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- 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. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes

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

- Geographic Limitation.** A waiver of statewide requirements 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 statewide requirements 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

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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

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*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 inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:  
Illinois secured public input into the development of this waiver through two separate statements of public notice and input. One form of public notice was electronic through a posting on the HFS website; <http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx>; and on the website of the Operating Agency, the Illinois Division of Developmental Disabilities found at: <http://www.dhs.state.il.us/page.aspx?item=45915>. For persons that may not have access to the website, a second, non-electronic publication of the waiver renewal was made available. This non-electronic publication is the Illinois Register issued on May 29, 2015. In the two methods of public notification, the dates of the 30 day public input period were identified. The 30 day public input period is from May 29, 2015 through June 28, 2015.

In addition to these two methods of notification, the Operating Agency sent an e-mail blast with the same language found in the Illinois Register and on the website to its stakeholders which includes provider agencies and care coordination entities. These entities were asked to inform the public of the opportunities as described in the public notice to access a copy of the waiver application from the HFS or DHS - DD websites described above, or to review a copy at the Independent Service Coordination (ISC) agencies across the State. To locate the closest ISC agency or see a listing of all ISC agencies, persons were instructed to use the Office Locator on the DHS website at <http://www.dhs.state.il.us/page.aspx?module=12&officetype=3&county>.

The public interested in providing input was asked to e-mail their feedback to the HFS web portal e-mail address: [HFS.SWTransitionPlan@illinois.gov](mailto:HFS.SWTransitionPlan@illinois.gov); or mail their input to the Illinois Department of Healthcare and Family Services, Attn: Waiver Management, 201 South Grand Ave East, 2nd FL, Springfield, IL 62763.

As discussed above, the public notification indicates that all stakeholders have the opportunity to provide the State input either electronically through the website or non-electronically through the U.S. mail. In addition, the full waiver renewal application is available to the public to review and comment and Illinois has provided multiple levels of contact with our stakeholders.

A summary of the public notice and comments has been incorporated into the renewal prior to submission to federal CMS. This summary includes modifications to the initial waiver renewal and reasons why the State is not adopting specific comments or recommendations.

In addition, Illinois informed via U.S. Mail and e-mail and sought feedback from our representative of the Tribal Authority or First Nation of Illinois' intent to renew this waiver on January 9, 2015. On May 26, 2015, a second letter was sent via U.S. Mail and e-mail informing of the extension of this waiver and its' posting for public comment. In all letters to the Authority, HFS has offered to meet and discuss the waiver.

Specific to Statewide Transition Plan:

Illinois established a LTSS Inter-Agency workgroup in April, 2014 to address the Statewide Transition Plan (STP) in response to the HCBS new regulations. This workgroup continues to meet throughout the implementation of the STP.

In accordance with CMS-2249-F/2296-F, (iii), Illinois provided a 32-day public notice and comment period with two

statements of public notice, one non-electronic and one electronic with several methods to inform and engage the public in providing the State with feedback on the draft Statewide Transition Plan. In addition, Illinois informed and sought feedback from our representative of the Tribal Authority or First Nation. The Plan reflects input received and has been modified accordingly.

Illinois' strategies to comply with public notice and input are detailed in Illinois Statewide Transition Plan to Comply with the Department of Health and Human Services Centers for Medicare and Medicaid (CMS) 2249-F and 2296-F Regarding Home and Community-Based Services (HCBS) Settings Rules in Illinois' 1915c Waivers which was submitted to federal CMS on March 16, 2015 and can be found at: <http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Transition/Pages/default.aspx>.

In addition, Illinois hosted six public listening forums at which 175 stakeholders signed attendance sheets and a webinar in which 265 individuals participated.

The input that was received was incorporated into the Transition Plan or there was indication in the Plan of either the inability of the State to respond or how the State intends to respond to comment in the future.

- 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)

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- A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:** **Illinois**

**Zip:**

**Phone:**  **Ext:**   **TTY**

**Fax:**

**E-mail:**

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

|                    |                                                                     |                                  |                                     |
|--------------------|---------------------------------------------------------------------|----------------------------------|-------------------------------------|
| <b>Last Name:</b>  | <input type="text" value="Hoskin"/>                                 |                                  |                                     |
| <b>First Name:</b> | <input type="text" value="Reta"/>                                   |                                  |                                     |
| <b>Title:</b>      | <input type="text" value="Associate Director"/>                     |                                  |                                     |
| <b>Agency:</b>     | <input type="text" value="Department of Human Services"/>           |                                  |                                     |
| <b>Address:</b>    | <input type="text" value="Division of Developmental Disabilities"/> |                                  |                                     |
| <b>Address 2:</b>  | <input type="text" value="319 E. Madison, Suite 3M"/>               |                                  |                                     |
| <b>City:</b>       | <input type="text" value="Springfield"/>                            |                                  |                                     |
| <b>State:</b>      | <b>Illinois</b>                                                     |                                  |                                     |
| <b>Zip:</b>        | <input type="text" value="62701"/>                                  |                                  |                                     |
| <b>Phone:</b>      | <input type="text" value="(217) 782-9421"/>                         | <b>Ext:</b> <input type="text"/> | <input type="checkbox"/> <b>TTY</b> |
| <b>Fax:</b>        | <input type="text" value="(217) 558-2799"/>                         |                                  |                                     |
| <b>E-mail:</b>     | <input type="text" value="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.

|                         |                                                                                      |
|-------------------------|--------------------------------------------------------------------------------------|
| <b>Signature:</b>       | <input type="text" value="Kelly Cunningham"/><br>State Medicaid Director or Designee |
| <b>Submission Date:</b> | <input type="text" value="Jun 13, 2017"/>                                            |

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

|                    |                                                                                    |
|--------------------|------------------------------------------------------------------------------------|
| <b>Last Name:</b>  | <input type="text" value="Teresa"/>                                                |
| <b>First Name:</b> | <input type="text" value="Hursey"/>                                                |
| <b>Title:</b>      | <input type="text" value="Acting Medicaid Director"/>                              |
| <b>Agency:</b>     | <input type="text" value="Illinois Department of Healthcare and Family Services"/> |
| <b>Address:</b>    |                                                                                    |

|                   |                            |             |                                                   |
|-------------------|----------------------------|-------------|---------------------------------------------------|
|                   | 201 S. Grand Avenue        |             |                                                   |
| <b>Address 2:</b> |                            |             |                                                   |
| <b>City:</b>      | Springfield                |             |                                                   |
| <b>State:</b>     | Illinois                   |             |                                                   |
| <b>Zip:</b>       | 62763                      |             |                                                   |
| <b>Phone:</b>     | (217) 782-2570             | <b>Ext:</b> | <input type="text"/> <input type="checkbox"/> TTY |
| <b>Fax:</b>       | (217) 782-5672             |             |                                                   |
| <b>E-mail:</b>    | Teresa.Hursey@illinois.gov |             |                                                   |

## Attachments

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### Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

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

Specify the transition plan for the waiver:

The State has developed a Corrective Action Plan for Service Plan Development. The CAP will be fully implemented by 9/30/17.

The State will submit to CMS an Administrative Authority (AA) and Health and Welfare (HW) CAP for approval by 7/31/17. By 9/30/17 the state will submit a technical amendment to the waiver that incorporates the AA and Health and Welfare CAP into the waiver program.

By October 1, 2017 the state will submit a technical amendment to incorporate the AA and H&W CAP into the waiver program. The October 1, 2017 amendment should also include the removal of the Service Plan Development CAP.

### Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal*

*HCBS setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

The following represent key components of the Statewide Transition Plan and represent language taken directly from the Plan.

The HCBS regulations require States to ensure that individuals receiving Long-Term Services and Supports (LTSS) have full access to the benefits of community living and the opportunity to receive services in the most-integrated setting appropriate and that those rights and privileges are comparable to those afforded to Non-Waiver participants in the community.

In the spring of 2014, the Illinois Department of Healthcare & Family Services (HFS) convened an LTSS Inter-Agency workgroup consisting of representatives of: HFS as the State Medicaid Authority responsible to federal CMS for oversight of the State's nine 1915(c) Waivers; the Illinois Department of Human Services (DHS) and its Divisions of Developmental Disabilities (DDD), Mental Health (DMH), Alcoholism and Substance Abuse (DASA), Rehabilitation Services (DRS); the University of Illinois at Chicago Division of Specialized Care for Children (DSCC); and the Illinois Department on Aging (IDoA).

Illinois' Statewide Transition Plan included an assessment of existing State statutes, regulations, standards, policies, licensing requirements, and other provider requirements, including whether waiver settings' comply with the regulations as outlined at 42 CFR 441.301(c)(4)(5) and 42 CFR 441.710(a)(1)(2). Furthermore, the Statewide Transition Plan describes the remediation steps Illinois plans to implement to assure full and on-going compliance with the HCBS settings requirements, with specific timeframes for already-identified actions and deliverables.

HFS contracted with the University of Illinois Springfield (UIS) Survey Research Office to assist the LTSS Inter-Agency workgroup with the development of the methodology for the residential and non-residential settings surveys, including the development of survey questions and analysis of survey responses, to provide the State with a non-biased assessment of current practices. The survey questions were reviewed by each State agency, tested with staff from several community-based HCBS waiver residential settings and revised by the workgroup so as to be inclusive of the variety of services offered in Illinois' residential and non-residential HCBS settings. Two versions of the survey were created: one for residential settings and one for non-residential settings providing HCBS waiver services. Completion of the surveys by individual setting/sites was required.

The State held a webinar on February 11, 2015. This webinar was targeted to – HCBS waivers providers and provider organizations and to HCBS waiver participants and their families, guardians and representatives. In addition, six Regional Public Listening Forums were held at accessible locations throughout the State during the 32-day public comment period originally planned for January 15, 2015 - February 15, 2015 and subsequently extended to February 24, 2015. There was no cost to attend. Parking was available at all locations and accommodations were provided when requested to anyone who might need assistance with communication. Attendees were informed of the new HCBS regulations and its implications for HCBS settings and were given the opportunity to provide feedback and to ask questions. Those who commented were asked to submit a written version of their comments at the Forum. All written received and oral comments were transcribed and included in the Transition Plan.

Based upon follow-up site validation visits to provider settings, the State agencies under whose jurisdiction these settings operate along with HFS, will notify providers who are not in compliance with the new regulations. Specific explanations are to be presented to the providers regarding areas of their service setting and practice which do not comply with the new regulations.

The State intends to make a recommendation as to whether Illinois' HCBS settings qualify for "Heightened Scrutiny" on a case-by-case basis.

The State intends to work with HCBS waiver providers to bring their settings into compliance with the new regulations. When remediation actions have failed, it will become necessary to inform participants and their families, guardians or representatives that an alternate compliant setting will need to be selected.

The development of the Illinois Statewide Transition Plan was subject to public input, as required at 42 CFR 441.301(6)(B)(iii) and 42 CFR 441.710(3)(iii) and describes the process Illinois utilized for obtaining initial stakeholder input as well as

plans to maintain stakeholder dialogue as the Transition Plan is modified.

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

## **Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

### Public Input and Process

In accordance with "Policies Concerning Waiver Amendments" page 26 of the Instructions, Technical Guide and Review Criteria, dated January 2015 which states that "the state is required to establish a public input process specifically for HCBS changes that are substantive in nature," HFS and the DHS - Division of DD sought public comment beginning on May 29, 2015 through June 28, 2015. Public notification of this 30 day comment period with details on how to provide input was posted in the Illinois Register on May 29, 2015. Persons interested in providing input were asked to email feedback to the HFS web portal email address: HFS.SWTransitionPlan@illinois.gov; or mail their input to HFS. In addition, the DHS-Division of DD notified its provider network via e-mail with the same information. The network was asked to share information to all stakeholders, plus DHS-DD requested that the Independent Service Coordination (ISC) agencies across the State provide the ability to access a hard copy of the proposed waiver renewal application at any of the ISC agencies across the State for persons who may be unable to access the website.

This waiver was posted for public comment at the same time as another DHS-DD waiver. There appeared to be few letters specific to this waiver; however of the five separate letters or e-mails received, HFS as the Medicaid Authority and DHS-DD as the Operating Authority, believe the following points that were made apply to this waiver.

Several themes emerged. Below are the identified themes and the state's response:

1. Adopt an emphasis on Independent Service Coordination

- Currently the state contacts with Independent Service Coordination (ISC) agencies which service as the single point of entry for all three DD waiver programs. The state believes that practices identified in the waiver renewal speak to participant centered planning and the role of the ISC as an independent care coordination in role of developing and monitoring the delivery of services identified in the participant centered service plan.

2. Allow two waivers to function in tandem

- While this may appear to be helpful idea, a participant is placed in the waiver that best meets their identified needs. A participant cannot be in two waivers at the same time. However, the state currently allows children to move between the two children's waivers. Families are encouraged to work with the ISC agency and the DHS-DD as the OA to obtain authorization for waiver services if needs change.

3. Reserve capacity for persons transitioning from the state's Medically Fragile Technology Dependent Waiver (MFTD)

- The state agrees that there may be candidates in the MFTD waiver that might also be eligible for this waiver at less cost. Unfortunately, the state has a long wait list for this waiver. Participants in the MFTD waiver have options available to them through access of State Plan services or if determined eligible, receive services through our Persons with Disabilities waiver which currently does not have a wait list.

4. Inclusion of psychological testing as part of the assessment process

- In response to public input, the OA recently made changes to the eligibility process regarding psychological evaluations. In order to streamline the eligibility assessment process, psychological assessments for persons in the severe/profound range of intellectual disability will no longer require a current evaluation (within five years of the application date).

5. Various tracking methodologies

- The state believes the ideas received are helpful in better understanding the populations we serve and that data reports should be shared, but the data and questions are not specific to the waiver application.

6. Addressing aging-out of the waiver

- The waiver does contain language regarding the health and welfare of individuals who transition out of the waiver and all children are provided the opportunity to apply for the HCBS Waiver for Adults with DD.

7. Strengthen supports for the families of children with I/DD, including affordable childcare to enable parents to work, transportation, safe and affordable housing and increased access to behavioral health services for children who are dually diagnosed.

- It is beyond the scope of these waivers to address all of the needs of low income families caring for children with developmental disabilities. The OA and MA will continue to advocate for the interests of children and families to the full extent of the state's resources.

8. Eliminate the waiting list for children with developmental disabilities. And immediately increase capacity of the Children's Support Waiver to 2000 with continued growth in capacity over the next five years.

- Unfortunately, the State is faced with a severe financial crisis and is not in a fiscal position to increase waiver capacity at this time.

No substantive changes were made to this waiver since posting for public comment. The State did renumber and made other minor changes to Performance Measures. But again, no substantive changes were made.

## Appendix A: Waiver Administration and Operation

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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

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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 (MA), conducts the following activities:

- As changes are developed, the Medicaid Agency reviews and approves all changes to Medicaid policies, rules and regulations prior to implementation.
- As appeals are requested, the Medicaid Agency conducts appeals involving waiver services and issues final administrative decisions, providing the independent hearing officer for all appeal hearings.

The MA conducts all waiver appeal hearings using trained hearing officers and does not delegate this function to the OA.

- As rate changes are proposed, the Medicaid Agency reviews and approves changes to the Operating Agency's payment rate methodologies.

Annually, the Medicaid Agency conducts fiscal monitoring by conducting validation reviews from the Operating Agency post-payment audit report of a representative sample of participants, and by using performance measures and sampling described in Appendix A.

- Quarterly, staff from the Medicaid Agency, through their membership on the Quality Management Committee, meet with staff of the Operating Agency to review data collected for each Waiver Performance Measure. The committee is responsible for the overall coordination of quality management activities. The committee is charged with reviewing data for the waiver performance measures, tracking and analyzing the findings, and discussing and determining systematic strategies for remediation based on the evidence presented.

Annually, 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.

The delegation of authority to the Department of Human Services, Division of Developmental Disabilities, the Operating Agency, is through an interagency agreement, which is reviewed annually by the two Departments and updated as necessary.

## 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 Intellectual Disability Professionals (QIDPs).

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

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- 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

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- 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. Results are shared with the Medicaid Agency on a quarterly basis as part of the Waiver Quality Management Committee.

## Appendix A: Waiver Administration and Operation

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- 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                                                        | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Waiver enrollment managed against approved limits                                    | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Waiver expenditures managed against approved levels                                  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Level of care evaluation                                                             | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Review of Participant service plans                                                  | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Prior authorization of waiver services                                               | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Utilization management                                                               | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Qualified provider enrollment                                                        | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Execution of Medicaid provider agreements                                            | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Establishment of a statewide rate methodology                                        | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Rules, policies, procedures and information development governing the waiver program | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Quality assurance and quality improvement activities                                 | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

**a. Methods for Discovery: Administrative Authority**

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

**i. Performance Measures**

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

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

*Where possible, include numerator/denominator.*

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

**Performance Measure:**

**A1 Number and percent of rate methodology changes approved by the MA and submitted for Public Notice prior to implementation by the OA. Numerator: Number of rate methodology changes approved by the MA prior to implementation by the OA. Denominator: Total number of rate methodology changes adopted.**

**Data Source (Select one):**

**Reports to State Medicaid Agency on delegated**

If 'Other' is selected, specify:

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

|  |                                                                           |                      |
|--|---------------------------------------------------------------------------|----------------------|
|  |                                                                           | <input type="text"/> |
|  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |                      |

**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"/> <b>Other</b><br>Specify:<br><input type="text"/>      | <input checked="" type="checkbox"/> Annually                              |
|                                                                                | <input type="checkbox"/> Continuously and Ongoing                         |
|                                                                                | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |

**Performance Measure:**

**A2 Number and percent of waiver program policies approved by the MA prior to OA dissemination and implementation. Numerator: Number of waiver program policies approved by the MA prior to OA dissemination and implementation. Denominator: Total number of waiver program policy changes implemented.**

**Data Source (Select one):**

**Reports to State Medicaid Agency on delegated**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies):                                                    |
|-----------------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <input checked="" 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<br>Confidence Interval =<br><input type="text"/> |

|                                                                           |                                                                           |                                                                                       |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> <b>Annually</b>                       | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/> |
|                                                                           | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>             |
|                                                                           | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |                                                                                       |

**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"/> <b>State Medicaid Agency</b>               | <input type="checkbox"/> <b>Weekly</b>                                    |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                    | <input type="checkbox"/> <b>Monthly</b>                                   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                               | <input type="checkbox"/> <b>Quarterly</b>                                 |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>      | <input checked="" type="checkbox"/> <b>Annually</b>                       |
|                                                                                | <input type="checkbox"/> <b>Continuously and Ongoing</b>                  |
|                                                                                | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |

**Performance Measure:**

**A3 Number and percent of participant reviews conducted by the OA according to the sampling methodology specified in the approved waiver. Numerator: Number of participant reviews conducted by the OA according to the sampling methodology in the approved waiver. Denominator: Total number of participant reviews required according to the approved sampling methodology.**

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

|                                                                    |                                                                    |                                                                                                 |
|--------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
|                                                                    |                                                                    | <b>Review</b>                                                                                   |
| <input type="checkbox"/> Sub-State Entity                          | <input type="checkbox"/> Quarterly                                 | <input type="checkbox"/> Representative Sample<br>Confidence Interval =<br><input type="text"/> |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> Annually                       | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>                  |
|                                                                    | <input checked="" type="checkbox"/> Continuously and Ongoing       | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                              |
|                                                                    | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> |                                                                                                 |

**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                                            |
| <input type="checkbox"/> Sub-State Entity                                             | <input type="checkbox"/> Quarterly                                          |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                    | <input checked="" type="checkbox"/> Annually                                |
|                                                                                       | <input type="checkbox"/> Continuously and Ongoing                           |
|                                                                                       | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>          |

**Performance Measure:**

**A4 Number & percent of findings of noncompliance in the area of requests for services subject to prior authorization with evidence of remediation within 90 days of discovery.**  
**N: Number of findings of noncompliance in the area of services subject to prior approval with evidence of remediation within 90 days of discovery. D: Total number of findings in area of prior authorization of services.**

**Data Source (Select one):**

**Reports to State Medicaid Agency on delegated**

If 'Other' is selected, specify:

**OA database**

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b> <i>(check each that applies):</i>                                      |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <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<br>Confidence Interval =<br><input type="text"/> |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                           | <input checked="" type="checkbox"/> Annually                                        | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>                  |
|                                                                                              | <input checked="" type="checkbox"/> Continuously and Ongoing                        | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                              |
|                                                                                              | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                  |                                                                                                 |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**A5 Number and percent of findings of noncompliance in the area of Waiver provider agreements on file at the MA with evidence of remediation within 90 days of discovery. N: Number of findings of noncompliance in the area of Waiver provider agreements on file at the MA with evidence of remediation within 90 days of discovery. D: Total number of findings in the area of Waiver provider agreements.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**MA MMIS**

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

**Data Aggregation and Analysis:**

| <b>Responsible Party for data aggregation and analysis</b><br><i>(check each that applies):</i> | <b>Frequency of data aggregation and analysis</b><br><i>(check each that applies):</i> |
|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                                | <input type="checkbox"/> <b>Weekly</b>                                                 |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                     | <input type="checkbox"/> <b>Monthly</b>                                                |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                                | <input type="checkbox"/> <b>Quarterly</b>                                              |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                       | <input checked="" type="checkbox"/> <b>Annually</b>                                    |

|                                                                           |
|---------------------------------------------------------------------------|
| <input type="checkbox"/> <b>Continuously and Ongoing</b>                  |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |

- 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 findings identified during their monitoring. This includes assuring that individual issues are resolved. The OA requires corrective action plans from providers/ISSAs for all identified issues within 10 working days of discovery. These plans must document resolution or plans for resolution, including responsible parties, actions to be taken, and time frames. The OA accepts or requests modifications to the plan within 30 days from receipt.

Types of remediation for individual issues may include, but are not limited to, service plan modification, re-education of workers, enhanced monitoring of the participant’s services, change in site selection, change in roommate, change of providers, reassessment of need, consultation, etc.

Additional remediation actions may be taken with providers. These actions may include, but are not limited to, enhanced monitoring of the provider, recoupment of payments, prohibition of accepting new participants, and termination of the Medicaid Provider Agreement.

All data collected, including the timeliness of remediation activities, is summarized quarterly and shared with the Waiver Quality Management Committee which meets quarterly. The data is analyzed and evaluated for trends on a quarterly and annual basis. As trends are identified, systemic remediation actions are identified and implemented.

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

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

- ii. **Remediation Data Aggregation**

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

| <b>Responsible Party</b> (check each that applies):                       | <b>Frequency of data aggregation and analysis</b> (check each that applies): |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>          | <input type="checkbox"/> <b>Weekly</b>                                       |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>               | <input type="checkbox"/> <b>Monthly</b>                                      |
| <input type="checkbox"/> <b>Sub-State Entity</b>                          | <input type="checkbox"/> <b>Quarterly</b>                                    |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> <b>Annually</b>                          |

|                                                                           |
|---------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><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 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 one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

| Target Group                                                                                            | Included                            | Target SubGroup               | Minimum Age          | Maximum Age          |                          |
|---------------------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------|----------------------|----------------------|--------------------------|
|                                                                                                         |                                     |                               |                      | Maximum Age Limit    | No Maximum Age Limit     |
| <input type="checkbox"/> <b>Aged or Disabled, or Both - General</b>                                     |                                     |                               |                      |                      |                          |
|                                                                                                         | <input type="checkbox"/>            | Aged                          | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |
|                                                                                                         | <input type="checkbox"/>            | Disabled (Physical)           | <input type="text"/> | <input type="text"/> |                          |
|                                                                                                         | <input type="checkbox"/>            | Disabled (Other)              | <input type="text"/> | <input type="text"/> |                          |
| <input type="checkbox"/> <b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>               |                                     |                               |                      |                      |                          |
|                                                                                                         | <input type="checkbox"/>            | Brain Injury                  | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |
|                                                                                                         | <input type="checkbox"/>            | HIV/AIDS                      | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |
|                                                                                                         | <input type="checkbox"/>            | Medically Fragile             | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |
|                                                                                                         | <input type="checkbox"/>            | Technology Dependent          | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> <b>Intellectual Disability or Developmental Disability, or Both</b> |                                     |                               |                      |                      |                          |
|                                                                                                         | <input checked="" type="checkbox"/> | Autism                        | 3                    | 21                   | <input type="checkbox"/> |
|                                                                                                         | <input checked="" type="checkbox"/> | Developmental Disability      | 3                    | 21                   | <input type="checkbox"/> |
|                                                                                                         | <input checked="" type="checkbox"/> | Intellectual Disability       | 3                    | 21                   | <input type="checkbox"/> |
| <input type="checkbox"/> <b>Mental Illness</b>                                                          |                                     |                               |                      |                      |                          |
|                                                                                                         | <input type="checkbox"/>            | Mental Illness                | <input type="text"/> | <input type="text"/> |                          |
|                                                                                                         | <input type="checkbox"/>            | Serious Emotional Disturbance | <input type="text"/> | <input type="text"/> |                          |

**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 childrens 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.

- 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 Childrenf'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. 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      | 295                                 |
| Year 2      | 295                                 |
| Year 3      | 295                                 |
| Year 4      | 295                                 |
| Year 5      | 295                                 |

- 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      | <input type="text"/>                                               |
| Year 2      | <input type="text"/>                                               |
| Year 3      | <input type="text"/>                                               |
| Year 4      | <input type="text"/>                                               |
| Year 5      | <input type="text"/>                                               |

## Appendix B: Participant Access and Eligibility

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

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):
- Not applicable. The state does not reserve capacity.**
  - The State reserves capacity for the following purpose(s).**

## Appendix B: Participant Access and Eligibility

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

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- The waiver is not subject to a phase-in or a phase-out schedule.**
  - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**
- e. **Allocation of Waiver Capacity.**

*Select one:*

- Waiver capacity is allocated/managed on a statewide basis.**
- Waiver capacity is allocated to local/regional non-state entities.**

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

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

Enrollments are completed as capacity becomes available as a result of turnover or additional funds are redirected or newly appropriated by the State legislature.

Entry to the Waiver is offered only to individuals who are determined to be in a crisis situation. The State's guidance for determining the existence of a crisis situation is made public on the Operating Agency's website at

[http://www.dhs.state.il.us/OneNetLibrary/27896/documents/By\\_Division/Division%20of%20DD/Community%20Emergency%20Criteria%20-%20Children.pdf](http://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/Division%20of%20DD/Community%20Emergency%20Criteria%20-%20Children.pdf). The initial recommendation for a crisis authorization is made by one of the Independent Service Coordination agencies under contract with the OA —the same entities that conduct PUNS assessments and enrollments. Each recommendation is reviewed by the Operating Agency.

Unlike the Children's Support Waiver, the State does not maintain a waiting list for this Waiver since out-of-home residential services are focused on only those children and adolescents who are determined to be in a crisis situation.

## 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 (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)  
 Working individuals with disabilities who buy into Medicaid (TWWIA 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:*

The state proposes to add:

- 1) Adults age 19 and above without dependent children and with income at or below 138% of the Federal Poverty Level (Adult ACA Population) as provided in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (the Act) and Section 42 CFR 435.119 of the federal regulations.
- 2) Former Foster Care group defined as: young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits and are eligible for services regardless of income and assets pertaining to Title IV-E children under Section 1902(a)(10)(A)(i)(IX) of the Act and Section 42 CFR 435.150 of the federal regulations.
- 3) Caretaker relatives specified at 42 CFR 435.110.
- 4) Children specified at 42 CFR 435.118.
- 5) Pregnant women specified at 42 CFR 435.116.

---

***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

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- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
- Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

*Select one and complete Appendix B-5.*

- All individuals in the special home and community-based waiver group under 42 CFR §435.217
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217

*Check each that applies:*

- A special income level equal to:

*Select one:*

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)

Specify percentage:

- A dollar amount which is lower than 300%.

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)

**Aged and disabled individuals who have income at:**

Select one:

- 100% of FPL**
- % of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

## Appendix B: Participant Access and Eligibility

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

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

- 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 uses spousal post-eligibility rules under §1924 of the Act. Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.**

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (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 (3 of 7)**

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

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

Answers provided in Appendix B-4 indicate that you do not need to 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 7)**

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

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

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:

- 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:



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**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:*



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## Appendix B: Participant Access and Eligibility

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

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

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

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

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

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## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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:

**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 (7 of 7)

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

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

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**i. Allowance for the personal needs of the waiver participant**

(select one):

- SSI standard**
- Optional State supplement standard**
- Medically needy income standard**
- The special income level for institutionalized persons**
- A percentage of the Federal poverty level**

Specify percentage:

- 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 formula:*

- Other**

*Specify:*

- ii. **If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

- Allowance is the same**  
 **Allowance is different.**

*Explanation of difference:*

- iii. **Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified 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 uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## 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:

**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 Intellectual Disability Professionals (QIDPs) as defined in Federal ICFIDD Regulations. QIDPs were formerly referred to as Qualified Support Professionals (QSPs).

- 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/IDD 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 QIDPs 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 an intellectual disability (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 an intellectual disability) 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, within two years for children ages 13 up to age 18 and within five years for individuals 18 up to 21.

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 five years or more. Results are maintained electronically by the Operating Agency for three or more years.

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**B1 Number and percent of new waiver applicants who had a level of care assessment indicating need for ICF/DD level of care prior to receipt of services.**

**Numerator:** Number of new applicants that complete level of care assessment.

**Denominator:** Number of total applicants.

**Data Source** (Select one):

**Program logs**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>                                   |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <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<br>Confidence Interval =<br><input type="text"/> |

|                                                                           |                                                                     |                                                                                       |
|---------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> <b>Annually</b>                 | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/> |
|                                                                           | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b> | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>             |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |                                                                     |                                                                                       |

**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"/> <b>State Medicaid Agency</b>               | <input type="checkbox"/> <b>Weekly</b>                                    |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                    | <input type="checkbox"/> <b>Monthly</b>                                   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                               | <input checked="" type="checkbox"/> <b>Quarterly</b>                      |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>      | <input checked="" type="checkbox"/> <b>Annually</b>                       |
|                                                                                | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       |
|                                                                                | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |

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

**Performance Measures**

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

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

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

**Performance Measures**

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

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

**Performance Measure:**

**B2 Number and percent of Waiver participants' LOC determinations that are completed as required by the State in adherence to all Waiver requirements. Num: Number of determinations that are completed at the time of enrollment as required by the State in adherence to all Waiver requirements. Den: Total number of determinations that are completed at the time of the prior waiver year's enrollments.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>                          |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> State Medicaid Agency                                               | <input type="checkbox"/> Weekly                                                     | <input type="checkbox"/> 100% Review                                                   |
| <input checked="" type="checkbox"/> Operating Agency                                         | <input type="checkbox"/> Monthly                                                    | <input checked="" type="checkbox"/> Less than 100% Review                              |
| <input type="checkbox"/> Sub-State Entity                                                    | <input type="checkbox"/> Quarterly                                                  | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95% |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                           | <input checked="" type="checkbox"/> Annually                                        | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>         |
|                                                                                              | <input checked="" type="checkbox"/> Continuously and Ongoing                        | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                     |
|                                                                                              | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                  |                                                                                        |

**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 checked="" type="checkbox"/> Quarterly                        |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>             | <input checked="" type="checkbox"/> Annually                         |
|                                                                                | <input checked="" type="checkbox"/> Continuously and Ongoing         |
|                                                                                | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>   |

**Performance Measure:**  
**B3 Number and percent of LOC determinations reviewed that were completed by a qualified evaluator. Numerator: Number of LOC determinations that were completed by a qualified evaluator. Denominator: Total number of LOC determinations reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies):                                           |
|-----------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> State Medicaid Agency                              | <input type="checkbox"/> Weekly                                    | <input type="checkbox"/> 100% Review                                                   |
| <input checked="" type="checkbox"/> Operating Agency                        | <input type="checkbox"/> Monthly                                   | <input checked="" type="checkbox"/> Less than 100% Review                              |
| <input type="checkbox"/> Sub-State Entity                                   | <input type="checkbox"/> Quarterly                                 | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95% |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>          | <input checked="" type="checkbox"/> Annually                       | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>         |
|                                                                             | <input checked="" type="checkbox"/> Continuously and Ongoing       | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                     |

|  |                                                                                                |  |
|--|------------------------------------------------------------------------------------------------|--|
|  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input style="width: 100%;" type="text"/> |  |
|--|------------------------------------------------------------------------------------------------|--|

**Data Aggregation and Analysis:**

| Responsible Party for data aggregation and analysis <i>(check each that applies):</i>          | Frequency of data aggregation and analysis <i>(check each that applies):</i>                   |
|------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                               | <input type="checkbox"/> <b>Weekly</b>                                                         |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                    | <input type="checkbox"/> <b>Monthly</b>                                                        |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                               | <input checked="" type="checkbox"/> <b>Quarterly</b>                                           |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input style="width: 100%;" type="text"/> | <input checked="" type="checkbox"/> <b>Annually</b>                                            |
|                                                                                                | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>                            |
|                                                                                                | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input style="width: 100%;" type="text"/> |

- 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 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 individual issues are resolved. The OA provides quarterly reports of these 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 <i>(check each that applies):</i>              | Frequency of data aggregation and analysis <i>(check each that applies):</i> |
|------------------------------------------------------------------|------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b> | <input type="checkbox"/> <b>Weekly</b>                                       |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>      | <input type="checkbox"/> <b>Monthly</b>                                      |
| <input type="checkbox"/> <b>Sub-State Entity</b>                 | <input type="checkbox"/> <b>Quarterly</b>                                    |
| <input type="checkbox"/> <b>Other</b>                            | <input checked="" type="checkbox"/> <b>Annually</b>                          |

|                                  |                                                                           |
|----------------------------------|---------------------------------------------------------------------------|
| Specify:<br><input type="text"/> |                                                                           |
|                                  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                  |
|                                  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><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 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

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### 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 QIDPs 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 QIDP presents individuals/legal representatives with all service options, including both Waiver and ICF/IDD services that the individual is eligible to receive, regardless of availability, in sufficient detail so they are able to make informed choices. If the individual/legal representative does not speak English, has limited proficiency or is non-verbal, the QIDP makes 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

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### 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                    |  |  |
| 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:**

**Sub-Category 1:**

|                             |                                              |
|-----------------------------|----------------------------------------------|
| 02 Round-the-Clock Services | 02011 group living, residential habilitation |
|-----------------------------|----------------------------------------------|

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

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

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### 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:**

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

- Service is included in approved waiver. There is no change in service specifications.

- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

**Service Definition (Scope):**

Adaptive equipment, as specified in the plan of care, includes (a) devices, controls, or appliances that enable participants to increase 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**


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**Service Type: Other Service**

**Service Name: Adaptive Equipment**

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**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:**


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:****Category 3:**

**Sub-Category 3:****Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

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

- (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:**

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 | 10040 behavior support |
|------------------------------------------------|------------------------|

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

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

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

**Service Definition (Scope):**

Behavior intervention and treatment includes a variety of individualized, behaviorally-based treatment models consistent with best practice and research on effectiveness that are directly related to 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"/> |
| Behavior Intervention and Treatment | <input checked="" type="checkbox"/> |
| Assistive Technology                | <input type="checkbox"/>            |

**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                                        | <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

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### 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 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:

**C1 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</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>                                          |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>State Medicaid Agency</b>                                        | <input type="checkbox"/> <b>Weekly</b>                                              | <input checked="" type="checkbox"/> <b>100% Review</b>                                                 |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                  | <input type="checkbox"/> <b>Monthly</b>                                             | <input type="checkbox"/> <b>Less than 100% Review</b>                                                  |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                             | <input type="checkbox"/> <b>Quarterly</b>                                           | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/> |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input checked="" type="checkbox"/> <b>Annually</b>                                 | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>                  |
|                                                                                              | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>                 | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                              |
|                                                                                              | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>           |                                                                                                        |

**Data Aggregation and Analysis:**

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

**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:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>                                   |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <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<br>Confidence Interval =<br><input type="text"/> |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                           | <input checked="" type="checkbox"/> Annually                                        | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>                  |
|                                                                                              | <input checked="" type="checkbox"/> Continuously and Ongoing                        | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                              |
|                                                                                              | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                  |                                                                                                 |

**Data Aggregation and Analysis:**

| <b>Responsible Party for data aggregation and analysis</b><br><i>(check each that applies):</i> | <b>Frequency of data aggregation and analysis</b><br><i>(check each that applies):</i> |
|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <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<br>Specify:                                                      | <input checked="" type="checkbox"/> Annually                                           |

|  |                                                                                                                           |
|--|---------------------------------------------------------------------------------------------------------------------------|
|  |                                                                                                                           |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                                                                  |
|  | <input type="checkbox"/> <b>Other</b><br>Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |

**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<br><i>(check each that applies):</i>                                 | Frequency of data collection/generation<br><i>(check each that applies):</i> | Sampling Approach<br><i>(check each that applies):</i>                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| <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<br>Confidence Interval =<br><div style="border: 1px solid black; height: 20px; width: 100%;"></div> |
| <input type="checkbox"/> Other<br>Specify:<br><div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input checked="" type="checkbox"/> Annually                                 | <input type="checkbox"/> Stratified<br>Describe Group:<br><div style="border: 1px solid black; height: 20px; width: 100%;"></div>                  |
|                                                                                                                       | <input checked="" type="checkbox"/> Continuously and                         | <input type="checkbox"/> Other                                                                                                                     |

|  |                                                                           |                                  |
|--|---------------------------------------------------------------------------|----------------------------------|
|  | <b>Ongoing</b>                                                            | Specify:<br><input type="text"/> |
|  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |                                  |

**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"/> <b>State Medicaid Agency</b>               | <input type="checkbox"/> <b>Weekly</b>                                    |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                    | <input type="checkbox"/> <b>Monthly</b>                                   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                               | <input type="checkbox"/> <b>Quarterly</b>                                 |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>      | <input checked="" type="checkbox"/> <b>Annually</b>                       |
|                                                                                | <input type="checkbox"/> <b>Continuously and Ongoing</b>                  |
|                                                                                | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |

**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:

| 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"/> <b>State Medicaid Agency</b>                       | <input type="checkbox"/> <b>Weekly</b>                             | <input checked="" type="checkbox"/> <b>100% Review</b>           |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                 | <input type="checkbox"/> <b>Monthly</b>                            | <input type="checkbox"/> <b>Less than 100% Review</b>            |
| <input type="checkbox"/> <b>Sub-State Entity</b>                            | <input type="checkbox"/> <b>Quarterly</b>                          | <input type="checkbox"/> <b>Representative Sample Confidence</b> |

|                                                                           |                                                                           |                                                                                       |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
|                                                                           |                                                                           | Interval =<br><input type="text"/>                                                    |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> <b>Annually</b>                       | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/> |
|                                                                           | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>             |
|                                                                           | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |                                                                                       |

**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"/> <b>State Medicaid Agency</b>               | <input type="checkbox"/> <b>Weekly</b>                                    |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                    | <input type="checkbox"/> <b>Monthly</b>                                   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                               | <input type="checkbox"/> <b>Quarterly</b>                                 |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>      | <input checked="" type="checkbox"/> <b>Annually</b>                       |
|                                                                                | <input type="checkbox"/> <b>Continuously and Ongoing</b>                  |
|                                                                                | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |

- 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</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>                                   |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <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<br>Confidence Interval =<br><input type="text"/> |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                           | <input checked="" type="checkbox"/> Annually                                        | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>                  |
|                                                                                              | <input type="checkbox"/> Continuously and Ongoing                                   | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                              |
|                                                                                              | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                  |                                                                                                 |

**Data Aggregation and Analysis:**

| <b>Responsible Party for data aggregation and analysis</b><br><i>(check each that applies):</i> | <b>Frequency of data aggregation and analysis</b><br><i>(check each that applies):</i> |
|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <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<br>Specify:                                                      | <input checked="" type="checkbox"/> Annually                                           |

|  |                                                                                                                           |
|--|---------------------------------------------------------------------------------------------------------------------------|
|  |                                                                                                                           |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                                                                  |
|  | <input type="checkbox"/> <b>Other</b><br>Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |

- 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 <i>(check each that applies):</i>                                                                       | Frequency of data aggregation and analysis <i>(check each that applies):</i>                                              |
|---------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                                                          | <input type="checkbox"/> <b>Weekly</b>                                                                                    |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                                               | <input type="checkbox"/> <b>Monthly</b>                                                                                   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                                                          | <input type="checkbox"/> <b>Quarterly</b>                                                                                 |
| <input type="checkbox"/> <b>Other</b><br>Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input checked="" type="checkbox"/> <b>Annually</b>                                                                       |
|                                                                                                                           | <input type="checkbox"/> <b>Continuously and Ongoing</b>                                                                  |
|                                                                                                                           | <input type="checkbox"/> <b>Other</b><br>Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div> |

**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, HCBS 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

## Appendix D: Participant-Centered Planning and Service Delivery

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

#### State Participant-Centered Service Plan Title:

Person Centered Plan (PCP)

- 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:*

- Other**

*Specify the individuals and their qualifications:*

The Individual Service and Support Advocate (ISSA) who is employed by the Independent Service Coordination (ISC) agency. The ISSAs are Qualified Intellectual Disabilities Professionals.

## 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:*

## Appendix D: Participant-Centered Planning and Service Delivery

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### 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.

Upon enrollment and annually thereafter each participant is given a statement of rights by the ISSA. The statement of rights can be found at: <http://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL462-1201.pdf>. The rights statement is consistent with the final Medicaid Home and Community Based Services rules CMS 2249F and 2296F.

The participant, the participant's family or legal representative, other individuals from the participant's support network as the participant, his or her family or guardian chooses, and the ISSA work together to develop the plan. Direct service providers do not play a direct role in the development of the plan, nor do they attend any planning meetings, unless the participant or his or her legal representative requests their participation. Progress notes and other documentation from current providers will be used to inform planning activities.

The ISSA provides information and support to enable the participant and his or her family or guardian to participate in and direct the planning process. The participant is informed of the types of services provided under the Waiver, as well as options of all willing and qualified providers. The options discussed and the choices made are documented as part of the planning process.

The plan itself and discussion of the plan is in plain language and in a manner accessible to the participant. The written plan may be produced in other formats, such as pictures, DVD, etc., to accommodate specific needs of the participant; however, the plan must exist in written format. The participant, his or her legal representative, if applicable, and the ISC all sign the plan. Providers responsible for the plan's implementation must also sign the plan.

The Plan must be approved, in writing, by the individual or guardian, if one has been appointed. The Operating Agency currently recognizes that an individual or guardian may refuse to sign a service plan or just remain unresponsive. 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; Such documentation will be accepted only in emergency situations or when harm would come to the individual by ceasing service provision.

The participant, his or her legal representative, if applicable, and direct service providers responsible for the plan's implementation are given a written copy of the plan by the ISSA when it is developed and updated. The participant and his or her legal guardian, if applicable, may also obtain a new copy of the plan by requesting it of the ISSA. Potential providers are given copies of the plan with the consent of the individual and his or her legal representative.

Annually the participant is informed about the process to request updates to the service plan and is informed of his/her right to request a revision to the service plan at any time.

## Appendix D: Participant-Centered Planning and Service Delivery

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### 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):

The ISSA employed by an Independent Service Coordination (ISC) agency completes the plan with the participant, the participant's family and/or legal guardian, and other individuals from the participant's support network as the family or guardian chooses. The ISSA and ISC agency may not provide any direct services in order to avoid a conflict of interest.

The plan is completed prior to initial service implementation and updated at least annually thereafter. The plan may be updated more frequently should the participant's needs and circumstances change. The time and location of the assessment and service plan meetings are convenient to the Waiver participant and guardian.

To begin the service planning process, ISSAs complete an assessment with the participant using a standard assessment tool developed by the OA with stakeholder input. The assessment collects and compiles information about the participant's strengths, needs, preferences, desired outcomes, health, and risk factors. The tool guides an interview with the participant. Topics covered include the participant's self-description, communication needs, relationships, living arrangements, work, abilities, health/medication issues, recreation, and community connections. The assessment tool is available upon request from the OA.

The use of the statewide, standardized assessment tool ensures information regarding the participant's goals, needs, and preferences are collected and compiled. The plan must then be based on and address the assessed needs, preferences, and desired outcomes. 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.

Upon enrollment and at least annually thereafter, during the planning process, the ISSA explains to the participant the types of services available under the Waiver, as well as all willing and qualified providers of services. The ISSA is responsible for informing participants that a listing of all qualified providers by type of provider is available on the OA's website. A written copy of the listing may be made available by the ISSA for those participants without internet access upon request. In addition, the Operating Agency maintains a video for participants and families regarding options within the developmental disabilities system. It is available on the Operating Agency's website at <http://www.dhs.state.il.us/page.aspx?item=87154>.

The ISSA is responsible for implementing the plan and monitoring its on-going implementation and effectiveness. The ISSA is charged with coordinating the various services chosen by the participant, including State Plan services for healthcare and medical needs, as well as generic supports. The Plan must be approved, in writing, by the individual or guardian, if one has been appointed. The Operating Agency currently recognizes that an individual or guardian may refuse to sign a service plan or just remain unresponsive. 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; Such documentation will be accepted only in emergency situations or when harm would come to the individual by ceasing service provision. The ISSA is responsible for ensuring that providers are identified and linked for any services identified that the participant may require beyond those authorized in the Waiver, i.e. medical services, non-emergency transportation to medical appointments, dental services, optometric services, etc. The ISSA must then monitor that the services are delivered as specified in the plan.

## 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 risk assessment requirements are posted on the OA's website at: <http://www.dhs.state.il.us/page.aspx?item=58999>.

The responsible QIDP 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

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### 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 (ISC) 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 offering that type of service in the desired geographic area. ISC entities will make referrals to those providers selected by the individual or family. These referrals must be documented on the DDPAS-10 form. The ISC ensures linkage with potential providers, and may, at the individual's or family's request, participate 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

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### 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 the Operating Agency reviews the adequacy of service plans through a representative sample during unannounced, on-site reviews. The Medicaid Agency staff participates in the reviews as they are available. A copy of the schedule of on-site reviews is shared with the MA in advance on a quarterly basis. The reviews consist of record reviews, interviews with participants and staff, and direct observation. Data from these reviews are aggregated by the Operating Agency and shared with the Medicaid Agency staff as part of the Waiver Quality Management Committee activity. This committee meets quarterly.

## Appendix D: Participant-Centered Planning and Service Delivery

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### 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:*

ISSA, employed by the ISC agency under contract with the OA, is specified.

## 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 ISSA is responsible for monitoring service plan implementation and participant health and welfare. The minimum frequency of contact, including direct, in-person contact with the participant, is quarterly. The ISSA ensures the service plan is being implemented, that the service plan continues to meet the needs of the participant, and that the services implemented are in accordance with the preferences and needs of the participant. The ISSA observes service provision, interviews the participant and provider staff, and reviews records. During the course of these reviews, in addition to service plan issues, the ISSA seeks to identify and address any unauthorized use of restraint or seclusion, any unreported allegations of abuse/neglect/exploitation, and any unreported complaints.

If the ISSA determines the plan is not meeting the individual's assessed needs, the ISSA shall work with the participant, family and guardian, if applicable, to ensure the plan is modified as necessary. In the event that conflicts arise with providers over service plan issues, the ISSA must assist the participant in resolving such conflicts. A resolution protocol, including time frames is posted on the OA's website at <http://www.dhs.state.il.us/page.aspx?item=56642>. The protocol includes a referral to the OA for intervention if issues cannot be resolved locally.

The OA monitors the case management and ISSA activity through a statistical valid 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, avoidance of claims. Using the annual statistically valid sample of Waiver participants, the Operating Agency reviews that Independent Service Coordination agencies inform participants of their right to choose providers and were given options of willing providers in the participant's identified geographic area of preference. The ISC agencies must communicate this information to participants during face-to-face discussions using written forms provided by the OA. The Operating Agency looks for evidence that the Independent Service Coordination agency shared the individual rights statement, documented the provider referrals made during the initial selection of providers, and annually discussed the ability to change providers during the service planning process.

- 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:*

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**D1 Number and percent of satisfaction survey respondents sampled who report they receive services to address their needs. Numerator: Number of respondents who report they received services to address their needs. Denominator: Total respondents sampled.**

**Data Source (Select one):**

**Analyzed collected data (including surveys, focus group, interviews, etc)**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i> |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> State Medicaid Agency                                               | <input type="checkbox"/> Weekly                                                     | <input type="checkbox"/> 100% Review                          |
| <input checked="" type="checkbox"/> Operating Agency                                         | <input type="checkbox"/> Monthly                                                    | <input checked="" type="checkbox"/> Less than 100% Review     |
|                                                                                              |                                                                                     |                                                               |

|                                                                    |                                                                    |                                                                                        |
|--------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Sub-State Entity                          | <input type="checkbox"/> Quarterly                                 | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95% |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> Annually                       | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>         |
|                                                                    | <input checked="" type="checkbox"/> Continuously and Ongoing       | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                     |
|                                                                    | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> |                                                                                        |

**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<br>Specify:<br><input type="text"/>             | <input checked="" type="checkbox"/> Annually                          |
|                                                                                | <input type="checkbox"/> Continuously and Ongoing                     |
|                                                                                | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>    |

**Performance Measure:**

**D2 Number and percent of participants reviewed whose service plan have strategies to address all health and safety risks indicated in the assessment.**

**Numerator: Number of ISPs with strategies to address all identified health and safety risks. Denominator: Total ISPs sampled with an assessed health and/or safety risk.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

|  |  |  |
|--|--|--|
|  |  |  |
|--|--|--|

| Responsible Party for data collection/generation<br><i>(check each that applies):</i> | Frequency of data collection/generation<br><i>(check each that applies):</i> | Sampling Approach<br><i>(check each that applies):</i>                                 |
|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> State Medicaid Agency                                        | <input type="checkbox"/> Weekly                                              | <input type="checkbox"/> 100% Review                                                   |
| <input checked="" type="checkbox"/> Operating Agency                                  | <input type="checkbox"/> Monthly                                             | <input checked="" type="checkbox"/> Less than 100% Review                              |
| <input type="checkbox"/> Sub-State Entity                                             | <input type="checkbox"/> Quarterly                                           | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95% |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                    | <input checked="" type="checkbox"/> Annually                                 | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>         |
|                                                                                       | <input checked="" type="checkbox"/> Continuously and Ongoing                 | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                     |
|                                                                                       | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>           |                                                                                        |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**D3 Number and percent of the participant individual service plans reviewed that address all participant needs identified by the assessment. Numerator: Participant service plans (ISPs) reviewed that addressed all identified needs. Denominator: All sample ISPs reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>                                 |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>State Medicaid Agency</b>                                        | <input type="checkbox"/> <b>Weekly</b>                                              | <input type="checkbox"/> <b>100% Review</b>                                                   |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                  | <input type="checkbox"/> <b>Monthly</b>                                             | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>                              |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                             | <input type="checkbox"/> <b>Quarterly</b>                                           | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95% |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input checked="" type="checkbox"/> <b>Annually</b>                                 | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>         |
|                                                                                              | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>                 | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                     |
|                                                                                              | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>           |                                                                                               |

**Data Aggregation and Analysis:**

| <b>Responsible Party for data aggregation and analysis</b><br><i>(check each that applies):</i> | <b>Frequency of data aggregation and analysis</b><br><i>(check each that applies):</i> |
|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                                | <input type="checkbox"/> <b>Weekly</b>                                                 |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                     | <input type="checkbox"/> <b>Monthly</b>                                                |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                                | <input checked="" type="checkbox"/> <b>Quarterly</b>                                   |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                       | <input checked="" type="checkbox"/> <b>Annually</b>                                    |

|                                                                           |
|---------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |

**Performance Measure:**  
**D4 Number and percent of participants' OA service plans that address all personal goals identified by the assessment. Numerator: number of OA service plans reviewed that addressed all personal goals identified by the assessment. Denominator: Total number of OA service plan reviewed.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>                                 |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>State Medicaid Agency</b>                                        | <input type="checkbox"/> <b>Weekly</b>                                              | <input type="checkbox"/> <b>100% Review</b>                                                   |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                  | <input type="checkbox"/> <b>Monthly</b>                                             | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>                              |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                             | <input type="checkbox"/> <b>Quarterly</b>                                           | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95% |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input checked="" type="checkbox"/> <b>Annually</b>                                 | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>         |
|                                                                                              | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>                 | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                     |
|                                                                                              | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>           |                                                                                               |

**Data Aggregation and Analysis:**

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

|                                                                           |                                                                           |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> <b>Operating Agency</b>               | <input type="checkbox"/> <b>Monthly</b>                                   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                          | <input checked="" type="checkbox"/> <b>Quarterly</b>                      |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> <b>Annually</b>                       |
|                                                                           | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       |
|                                                                           | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |

- b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

**Performance Measures**

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

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

**Performance Measure:**

**D5 Number and percent of ISP's reviewed that were developed in accordance with state requirements. N: Number of ISP's that were developed in accordance with state requirements. D: Total number of ISP's reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>                                 |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>State Medicaid Agency</b>                                        | <input type="checkbox"/> <b>Weekly</b>                                              | <input type="checkbox"/> <b>100% Review</b>                                                   |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                  | <input type="checkbox"/> <b>Monthly</b>                                             | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>                              |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                             | <input checked="" type="checkbox"/> <b>Quarterly</b>                                | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95% |
| <input type="checkbox"/> <b>Other</b><br>Specify:                                            | <input checked="" type="checkbox"/> <b>Annually</b>                                 | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:                                 |

|  |                                                                           |                                                                           |
|--|---------------------------------------------------------------------------|---------------------------------------------------------------------------|
|  |                                                                           |                                                                           |
|  | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |
|  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |                                                                           |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**D6 Number and percent of ISP's where the ISP was approved by all required entities within the required time frame. N: Number of ISP's whose contents were developed in accordance with State requirements. D: Total number of ISP's reviewed.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

|                                                                    |                                                                    |                                                                                        |
|--------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Sub-State Entity                          | <input checked="" type="checkbox"/> Quarterly                      | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95% |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> Annually                       | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>         |
|                                                                    | <input checked="" type="checkbox"/> Continuously and Ongoing       | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                     |
|                                                                    | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> |                                                                                        |

**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 checked="" type="checkbox"/> Quarterly                         |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>             | <input checked="" type="checkbox"/> Annually                          |
|                                                                                | <input checked="" type="checkbox"/> Continuously and Ongoing          |
|                                                                                | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>    |

**Performance Measure:**

**D7 Number and percent of ISP's where the ISP meeting occurred within 365 days of the previous ISP. N: Number of ISP's where the ISP meeting occurred within 365 days of the previous ISP. D: Total number of ISP's reviewed.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

|                                                                           |                                                                           |                                                                                               |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <b>collection/generation</b><br>(check each that applies):                | <i>(check each that applies):</i>                                         |                                                                                               |
| <input type="checkbox"/> <b>State Medicaid Agency</b>                     | <input type="checkbox"/> <b>Weekly</b>                                    | <input type="checkbox"/> <b>100% Review</b>                                                   |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>               | <input type="checkbox"/> <b>Monthly</b>                                   | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>                              |
| <input type="checkbox"/> <b>Sub-State Entity</b>                          | <input checked="" type="checkbox"/> <b>Quarterly</b>                      | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95% |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> <b>Annually</b>                       | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>         |
|                                                                           | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                     |
|                                                                           | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |                                                                                               |

**Data Aggregation and Analysis:**

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

- c. **Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.**

**Performance Measures**

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

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

**Performance Measure:**

**D8 Number and percent of waiver participants reviewed who have their Service Plan updated at least annually or in a timely manner when warranted by a change in the participant’s needs. Numerator: Number of participants who have had their service plans updated annually or in a timely manner when warranted by a change in their needs. Denominator: Number of waiver participants reviewed.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>                          |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> State Medicaid Agency                                               | <input type="checkbox"/> Weekly                                                     | <input type="checkbox"/> 100% Review                                                   |
| <input checked="" type="checkbox"/> Operating Agency                                         | <input type="checkbox"/> Monthly                                                    | <input checked="" type="checkbox"/> Less than 100% Review                              |
| <input type="checkbox"/> Sub-State Entity                                                    | <input type="checkbox"/> Quarterly                                                  | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95% |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                           | <input checked="" type="checkbox"/> Annually                                        | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>         |
|                                                                                              | <input checked="" type="checkbox"/> Continuously and Ongoing                        | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                     |
|                                                                                              | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                  |                                                                                        |

**Data Aggregation and Analysis:**

|                                   |                                          |
|-----------------------------------|------------------------------------------|
| <b>Responsible Party for data</b> | <b>Frequency of data aggregation and</b> |
|-----------------------------------|------------------------------------------|

|                                                                    |                                                                    |
|--------------------------------------------------------------------|--------------------------------------------------------------------|
| <b>aggregation and analysis</b> (check each that applies):         | <b>analysis</b> (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 checked="" type="checkbox"/> Quarterly                      |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> Annually                       |
|                                                                    | <input checked="" type="checkbox"/> Continuously and Ongoing       |
|                                                                    | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> |

- d. **Sub-assurance:** Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

**Performance Measures**

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

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

**Performance Measure:**

**D9 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.**

**Numerator:** Number of participants who received four quarterly ISSA visits.

**Denominator:** Total number of participants in sample.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

|                                                                           |                                                                           |                                                                                       |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
|                                                                           |                                                                           | Confidence Interval = 95%                                                             |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> <b>Annually</b>                       | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/> |
|                                                                           | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>             |
|                                                                           | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |                                                                                       |

**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"/> <b>State Medicaid Agency</b>                      | <input type="checkbox"/> <b>Weekly</b>                                      |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                           | <input type="checkbox"/> <b>Monthly</b>                                     |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                      | <input checked="" type="checkbox"/> <b>Quarterly</b>                        |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>             | <input checked="" type="checkbox"/> <b>Annually</b>                         |
|                                                                                       | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>         |
|                                                                                       | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>   |

**Performance Measure:**

**D10 Number and percent of participants reviewed who received the services in the scope, amount, duration and frequency as specified in their Individual Service Plan (ISP). Numerator: Number of participants who received the services as specified in their ISP. Denominator: Number of participants reviewed in the representative sample.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

|                                                         |                                                                           |                                                     |
|---------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------|
| <b>Responsible Party for data collection/generation</b> | <b>Frequency of data collection/generation (check each that applies):</b> | <b>Sampling Approach (check each that applies):</b> |
|---------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------|

|                                                                    |                                                                    |                                                                                        |
|--------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <i>(check each that applies):</i>                                  |                                                                    |                                                                                        |
| <input type="checkbox"/> State Medicaid Agency                     | <input type="checkbox"/> Weekly                                    | <input type="checkbox"/> 100% Review                                                   |
| <input checked="" type="checkbox"/> Operating Agency               | <input type="checkbox"/> Monthly                                   | <input checked="" type="checkbox"/> Less than 100% Review                              |
| <input type="checkbox"/> Sub-State Entity                          | <input type="checkbox"/> Quarterly                                 | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95% |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> Annually                       | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>         |
|                                                                    | <input checked="" type="checkbox"/> Continuously and Ongoing       | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                     |
|                                                                    | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> |                                                                                        |

**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                                             |
| <input type="checkbox"/> Sub-State Entity                                             | <input checked="" type="checkbox"/> Quarterly                                |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                    | <input checked="" type="checkbox"/> Annually                                 |
|                                                                                       | <input checked="" type="checkbox"/> Continuously and Ongoing                 |
|                                                                                       | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>           |

**Performance Measure:**

**D11 Number and percent of satisfaction survey respondents sampled who reported the receipt of all services listed in the service plan. Numerator: Number of**

respondents who reported receipt of all services in their ISP. Denominator: Total number of survey respondents.

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies):                                           |
|-----------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> State Medicaid Agency                              | <input type="checkbox"/> Weekly                                    | <input type="checkbox"/> 100% Review                                                   |
| <input checked="" type="checkbox"/> Operating Agency                        | <input type="checkbox"/> Monthly                                   | <input checked="" type="checkbox"/> Less than 100% Review                              |
| <input type="checkbox"/> Sub-State Entity                                   | <input type="checkbox"/> Quarterly                                 | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95% |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>          | <input checked="" type="checkbox"/> Annually                       | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>         |
|                                                                             | <input type="checkbox"/> Continuously and Ongoing                  | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                     |
|                                                                             | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> |                                                                                        |

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<br>Specify:<br><input type="text"/>             | <input checked="" type="checkbox"/> Annually                          |
|                                                                                | <input type="checkbox"/> Continuously and Ongoing                     |

**Other**  
Specify:

- e. **Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.**

**Performance Measures**

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

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

**Performance Measure:**

**D12 Number and percent of records reviewed that document participants were informed at least annually of the right to choose their providers. Numerator: Number of participant records reviewed that documented participants were informed at least annually of the right to choose their providers. Denominator: Total number of sample records reviewed.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>                                 |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>State Medicaid Agency</b>                                        | <input type="checkbox"/> <b>Weekly</b>                                              | <input type="checkbox"/> <b>100% Review</b>                                                   |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                  | <input type="checkbox"/> <b>Monthly</b>                                             | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>                              |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                             | <input type="checkbox"/> <b>Quarterly</b>                                           | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95% |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input checked="" type="checkbox"/> <b>Annually</b>                                 | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>         |
|                                                                                              | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>                 | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                     |
|                                                                                              | <input type="checkbox"/> <b>Other</b>                                               |                                                                                               |

|  |                                           |  |
|--|-------------------------------------------|--|
|  | Specify:                                  |  |
|  | <input style="width: 100%;" type="text"/> |  |

**Data Aggregation and Analysis:**

| Responsible Party for data aggregation and analysis <i>(check each that applies):</i>   | Frequency of data aggregation and analysis <i>(check each that applies):</i>            |
|-----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <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 checked="" type="checkbox"/> Quarterly                                           |
| <input type="checkbox"/> Other<br>Specify:<br><input style="width: 100%;" type="text"/> | <input checked="" type="checkbox"/> Annually                                            |
|                                                                                         | <input checked="" type="checkbox"/> Continuously and Ongoing                            |
|                                                                                         | <input type="checkbox"/> Other<br>Specify:<br><input style="width: 100%;" type="text"/> |

**Performance Measure:**

**D13 Number and percent of participants reviewed who were offered choice between/among waiver services (for which there has been a determination of need). N: Number of participants reviewed who were offered choice of waiver services. D: Total number of participants reviewed.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation <i>(check each that applies):</i> | Frequency of data collection/generation <i>(check each that applies):</i> | Sampling Approach <i>(check each that applies):</i>                                    |
|------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> State Medicaid Agency                                     | <input type="checkbox"/> Weekly                                           | <input type="checkbox"/> 100% Review                                                   |
| <input checked="" type="checkbox"/> Operating Agency                               | <input type="checkbox"/> Monthly                                          | <input checked="" type="checkbox"/> Less than 100% Review                              |
| <input type="checkbox"/> Sub-State Entity                                          | <input checked="" type="checkbox"/> Quarterly                             | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95% |
| <input type="checkbox"/> Other<br>Specify:                                         | <input checked="" type="checkbox"/> Annually                              | <input type="checkbox"/> Stratified Describe Group:                                    |

|  |                                                                           |                                                                           |
|--|---------------------------------------------------------------------------|---------------------------------------------------------------------------|
|  |                                                                           |                                                                           |
|  | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |
|  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |                                                                           |

**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"/> <b>State Medicaid Agency</b>               | <input type="checkbox"/> <b>Weekly</b>                                    |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                    | <input type="checkbox"/> <b>Monthly</b>                                   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                               | <input type="checkbox"/> <b>Quarterly</b>                                 |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>      | <input checked="" type="checkbox"/> <b>Annually</b>                       |
|                                                                                | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       |
|                                                                                | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |

- 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 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 findings are remediated. 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)**

|  |                                                   |
|--|---------------------------------------------------|
|  | <b>Frequency of data aggregation and analysis</b> |
|--|---------------------------------------------------|

|                                                                                                                              |                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
| <b>Responsible Party</b> (check each that applies):                                                                          | (check each that applies):                                                                                                   |
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                                                             | <input type="checkbox"/> <b>Weekly</b>                                                                                       |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                                                  | <input type="checkbox"/> <b>Monthly</b>                                                                                      |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                                                             | <input type="checkbox"/> <b>Quarterly</b>                                                                                    |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><div style="border: 1px solid black; height: 20px; width: 100%;"></div> | <input checked="" type="checkbox"/> <b>Annually</b>                                                                          |
|                                                                                                                              | <input type="checkbox"/> <b>Continuously and Ongoing</b>                                                                     |
|                                                                                                                              | <input type="checkbox"/> <b>Other</b><br>Specify:<br><div style="border: 1px solid black; height: 20px; width: 100%;"></div> |

**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**

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**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**

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**E-1: Overview (1 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (2 of 13)**

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

---

**Appendix E: Participant Direction of Services**

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**E-1: Overview (3 of 13)**

---

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

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**Appendix E: Participant Direction of Services**

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**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**

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**E-1: Overview (5 of 13)**

---

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (6 of 13)**

---

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (7 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (8 of 13)**

---

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (9 of 13)**

---

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (10 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (11 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (12 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (13 of 13)**

---

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

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**Appendix E: Participant Direction of Services**

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

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

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**Appendix E: Participant Direction of Services**

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**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.**

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**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.**

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**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.**

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**Appendix E: Participant Direction of Services**

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

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

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## 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:

- ISC and 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 employed by the ISC entities under contract with the OA are responsible for written notification when there is:
  - Determination of ineligibility for Waiver services.
  - Denial of choice of Waiver or institutional services.
  - Denial of choice of Waiver services or providers.
- 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 ISC 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.

## 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 Waiver Quality Management Committee collectively tracks the remediation activity.

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

Upon enrollment and annually thereafter, participants and guardians are informed by the ISSA of their options for making complaints and that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing. The notification is documented in the Rights of the Individuals form (IL462-1201). Options for filing complaints are also posted on the OA's website.

Individuals have three options for making a complaint:

- contacting the Independent Service Coordination (ISC) entity,
- contacting the OA directly, and
- filing a report of abuse, neglect, or exploitation with the Child Welfare Agency.

The participant, or guardian, if one has been appointed, may contact the OA directly at any time during the complaint process.

The type of complaints can include anything of concern to the participant or guardian, e.g., dissatisfaction with the participant's service plan, failure to implement the individual's service plan, quality of services or supports, risk of losing services, cleanliness of the home, issues with peers, money management, potential rate supplementation attempts, etc. In addition, individuals may identify issues that are program- or provider-wide and do not specifically apply to their individual services.

Complaints involving allegations of abuse, neglect, or exploitation are routed directly to the Child Welfare Agency regardless of the method used to make the complaint. Complaints exclude appeals for the denial, suspension, reduction or termination of services. Appeals should follow the appeal process outlined in the fair hearings section above.

When making a complaint, individuals may expect an initial response within two business days. In cases of reports of abuse, neglect, or exploitation, the initial contact will be within 24 hours.

Upon receipt of a complaint, the OA records the complaint in a database that documents the person making the complaint; the type of complaint; the substance of the complaint; the names of any participants, providers, and/or ISSAs involved; the person(s) at the OA assigned to review and address the complaint; action steps taken; final resolution; and dates of intake, action steps, and resolution. Reports are produced bi-weekly for managers within the OA to ensure complaints are being addressed on a timely basis.

The data are analyzed and evaluated for trends on a quarterly and annual basis. The summary reports are shared with the MA. As individual problems and trends are identified, proactive remediation is initiated. Based on the data, the OA and MA may develop system improvement plans by identifying the responsibilities of the MA and OA and identifying time frames for completion. The Waiver Quality Management Committee (QMC) tracks all system improvement plans until completion.

## 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 QIDP 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.

- 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 employed by the ISC entity 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. This information is to be provided to and discussed with individuals (or their guardians) by the ISC's at the time of Waiver enrollment and at annually.

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 QIDP 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 Coordination (ISC) 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 work with the Department of Children and Family Services (DCFS) and share information in order to improve remediation activities with providers serving participants.

- 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 3)

- a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

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

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

**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

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

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 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 Protection 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 developed a process that requires reports of unusual incidents within a prescribed time frame. As a result of an Action Plan approved by CMS, a formal process for state level review was developed.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

**b. Use of Restrictive Interventions. (Select one):**

- The State does not permit or prohibits the use of restrictive interventions**

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

- The 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.

- As a result of an Action Plan approved by CMS, a formal process for state level review was developed.
- 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.

As a result of an Action Plan approved by CMS, a formal process for state level review was developed.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

- c. **Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

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

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

- The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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 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 Protection 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 developed a process that requires reports of unusual incidents within a prescribed time frame. As a result of an Action Plan approved by CMS, a formal process for state level review was developed.

## 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 Intellectual Disability Professional (QIDP) 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 ILCS 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 ILCS 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 demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis,*

identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation." )

**i. Sub-Assurances:**

- a. **Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.** (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

**Performance Measures**

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

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

**Performance Measure:**

**G1 Number & percent of participant records reviewed that documented the participant (and/or guardian) received information/education about how to report abuse, neglect, exploitation & other critical incidents as specified in the approved waiver. N: Number of records where participant received information on how to report abuse/neglect. D: Number of participants in the sample.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation (check each that applies): | Frequency of data collection/generation (check each that applies): | Sampling Approach (check each that applies):                                           |
|-----------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> State Medicaid Agency                              | <input type="checkbox"/> Weekly                                    | <input type="checkbox"/> 100% Review                                                   |
| <input checked="" type="checkbox"/> Operating Agency                        | <input type="checkbox"/> Monthly                                   | <input checked="" type="checkbox"/> Less than 100% Review                              |
| <input type="checkbox"/> Sub-State Entity                                   | <input type="checkbox"/> Quarterly                                 | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95% |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>          | <input checked="" type="checkbox"/> Annually                       | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>         |
|                                                                             | <input checked="" type="checkbox"/> Continuously and Ongoing       | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                     |
|                                                                             | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> |                                                                                        |

|  |                      |  |
|--|----------------------|--|
|  | <input type="text"/> |  |
|--|----------------------|--|

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**G2 # and % of participants for whom identified instances of abuse, neglect or exploitation were reviewed & corrective measures were appropriately taken. N:# of participants for whom identified instances of abuse, neglect or exploitation were reviewed & corrective measures were appropriately taken. D: Total # of participants for whom identified incidents of abuse, neglect or exploitation were reviewed**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

| Responsible Party for data collection/generation <i>(check each that applies):</i> | Frequency of data collection/generation <i>(check each that applies):</i> | Sampling Approach <i>(check each that applies):</i>                                    |
|------------------------------------------------------------------------------------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> State Medicaid Agency                                     | <input type="checkbox"/> Weekly                                           | <input type="checkbox"/> 100% Review                                                   |
| <input checked="" type="checkbox"/> Operating Agency                               | <input type="checkbox"/> Monthly                                          | <input checked="" type="checkbox"/> Less than 100% Review                              |
| <input type="checkbox"/> Sub-State Entity                                          | <input type="checkbox"/> Quarterly                                        | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95% |
| <input type="checkbox"/> Other<br>Specify:                                         | <input checked="" type="checkbox"/> Annually                              | <input type="checkbox"/> Stratified<br>Describe Group:                                 |

|  |                                                                           |                                                                           |
|--|---------------------------------------------------------------------------|---------------------------------------------------------------------------|
|  |                                                                           |                                                                           |
|  | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |
|  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |                                                                           |

**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"/> <b>State Medicaid Agency</b>               | <input type="checkbox"/> <b>Weekly</b>                                    |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                    | <input type="checkbox"/> <b>Monthly</b>                                   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                               | <input type="checkbox"/> <b>Quarterly</b>                                 |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>      | <input checked="" type="checkbox"/> <b>Annually</b>                       |
|                                                                                | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       |
|                                                                                | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |

**Performance Measure:**

**G4 Number and percent of reportable deaths that were reported within the required timelines. Numerator: Number of reportable deaths reported within required timelines. Denominator: All reportable deaths.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Medicaid Eligibility and the Department of Children and Family Services file**

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

|                                                                    |                                                                    |                                                                                                 |
|--------------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Sub-State Entity                          | <input type="checkbox"/> Quarterly                                 | <input type="checkbox"/> Representative Sample<br>Confidence Interval =<br><input type="text"/> |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> Annually                       | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>                  |
|                                                                    | <input checked="" type="checkbox"/> Continuously and Ongoing       | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                              |
|                                                                    | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> |                                                                                                 |

**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<br>Specify:<br><input type="text"/>             | <input checked="" type="checkbox"/> Annually                         |
|                                                                                | <input checked="" type="checkbox"/> Continuously and Ongoing         |
|                                                                                | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>   |

- b. **Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

**Performance Measures**

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

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

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

**Performance Measure:**

**G6 # and % of participants for whom identified critical incidents other than abuse, neglect, or exploitation were reviewed & corrective measures were appropriately taken by the OA.N:# of participants for whom identified critical incidents other than A/N/E were reviewed & corrective measures were appropriately taken by the OA.D:Total # of OA participants for whom identified critical incidents were reviewed.**

**Data Source (Select one):**

**Critical events and incident reports**

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<br>Confidence Interval =<br><input type="text"/> |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                 | <input checked="" type="checkbox"/> Annually                              | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>                  |
|                                                                                    | <input checked="" type="checkbox"/> Continuously and Ongoing              | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                              |
|                                                                                    | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>        |                                                                                                 |

**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"/> <b>Operating Agency</b>               | <input type="checkbox"/> <b>Monthly</b>                                   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                          | <input checked="" type="checkbox"/> <b>Quarterly</b>                      |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> <b>Annually</b>                       |
|                                                                           | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       |
|                                                                           | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |

- c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

**Performance Measures**

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

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

**Performance Measure:**

**G7 The number and percent of participants reviewed with identified restrictive interventions where procedures were followed as specified in the approved waiver. Numerator: Number of restrictive interventions that followed required procedures. Denominator: Number of participants identified in the sample with at least one restrictive intervention.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>                                 |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>State Medicaid Agency</b>                                        | <input type="checkbox"/> <b>Weekly</b>                                              | <input type="checkbox"/> <b>100% Review</b>                                                   |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                  | <input type="checkbox"/> <b>Monthly</b>                                             | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>                              |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                             | <input type="checkbox"/> <b>Quarterly</b>                                           | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95% |
| <input type="checkbox"/> <b>Other</b>                                                        | <input checked="" type="checkbox"/> <b>Annually</b>                                 | <input type="checkbox"/> <b>Stratified</b>                                                    |

|                                  |                                                                           |                                                                           |
|----------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------|
| Specify:<br><input type="text"/> |                                                                           | Describe Group:<br><input type="text"/>                                   |
|                                  | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |
|                                  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |                                                                           |

**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"/> <b>State Medicaid Agency</b>               | <input type="checkbox"/> <b>Weekly</b>                                    |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                    | <input type="checkbox"/> <b>Monthly</b>                                   |
| <input type="checkbox"/> <b>Sub-State Entity</b>                               | <input checked="" type="checkbox"/> <b>Quarterly</b>                      |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>      | <input checked="" type="checkbox"/> <b>Annually</b>                       |
|                                                                                | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       |
|                                                                                | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |

- d. **Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.**

**Performance Measures**

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

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

**Performance Measure:**

**G8 Number and percent of participants reviewed who received the coordination**

**and support to access health care services identified in their service plan.  
 Numerator: Number of participants reviewed who received support to access health care services. Denominator: Number of participants in the sample with health care services identified in their ISP.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>                                 |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <b>State Medicaid Agency</b>                                        | <input type="checkbox"/> <b>Weekly</b>                                              | <input type="checkbox"/> <b>100% Review</b>                                                   |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                  | <input type="checkbox"/> <b>Monthly</b>                                             | <input checked="" type="checkbox"/> <b>Less than 100% Review</b>                              |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                             | <input type="checkbox"/> <b>Quarterly</b>                                           | <input checked="" type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval = 95% |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                    | <input checked="" type="checkbox"/> <b>Annually</b>                                 | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>         |
|                                                                                              | <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>                 | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                     |
|                                                                                              | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>           |                                                                                               |

**Data Aggregation and Analysis:**

| <b>Responsible Party for data aggregation and analysis</b><br><i>(check each that applies):</i> | <b>Frequency of data aggregation and analysis</b><br><i>(check each that applies):</i> |
|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>                                | <input type="checkbox"/> <b>Weekly</b>                                                 |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                                     | <input type="checkbox"/> <b>Monthly</b>                                                |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                                | <input checked="" type="checkbox"/> <b>Quarterly</b>                                   |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                       | <input checked="" type="checkbox"/> <b>Annually</b>                                    |

|                                                                           |
|---------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>       |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |

- 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 findings 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)**

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

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Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 2)

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### 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. ISSA staff who are QIDPs 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, QIDPs 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 <i>(check each that applies):</i>                | Frequency of Monitoring and Analysis <i>(check each that applies):</i> |
|--------------------------------------------------------------------|------------------------------------------------------------------------|
| <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 checked="" type="checkbox"/> Quarterly                          |
| <input type="checkbox"/> Quality Improvement Committee             | <input checked="" type="checkbox"/> Annually                           |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/> | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>     |

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 bulletins, 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 shares the data collected in the previous quarter on performance measures identified in the Waiver. Findings and identified trends are discussed. Changes to the QIS are made 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).

Provider agencies that are under contract with the Operating Agency and receive over \$750,000 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. Individual providers and businesses that are not under contract with the Operating Agency are not required to obtain and submit audits on their financial information. However, the Operating Agency reserves the right to audit any provider at any time.

The audits entail a complete and total financial and organizational review of the provider, including everything from financial to accounting processes, as well as sample business transactions. The audits are conducted in accordance with Governmental Accounting Standards (GAS). The Operating Agency performs desk reviews and a sample of on-site audit reviews of the required independent audits on an annual basis. Copies of the audits and consolidated financial reports are on file with the Operating Agency. The types of findings and discrepancies reported by auditors may include segregation of duties, issues with internal controls, inability to accurately prepare financial statements, misappropriation of funds, eligibility of services, accurate reporting of billings, and inappropriate costs.

This independent audit is an Operating Agency requirement and the Single Audit Act of 1984 (Act) and the Single Audit Act Amendments of 1996 do not apply to this Waiver. Medicaid payments received as reimbursement for providing services to Medicaid eligible individuals are not considered Federal awards under the Act and therefore providers are exempt from Federal audit requirements for these payments.

The Medicaid and Operating Agencies work cooperatively to review rates and provider claims. The MA delegates to the OA the financial oversight of claims.

The OA reviews 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 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.

Further, the OA selects a representative sample of claims and conducts post-payment reviews to verify whether the services were approved in the service plan. The OA summarizes the post payment review data and provides quarterly reports to the MA of their findings and any remediation activities (on an individual and systemic basis). Most post-payment reviews are done annually while some targeted reviews are done on an as needed basis. Remediation may include clarifying policy, retraining staff, providing technical assistance, voiding claims, increased monitoring, conducting focused reviews, or developing plans of correction, as appropriate.

The Medicaid Agency performs a validation review based on the OA report to verify that post-payment review procedures were followed and appropriate remediation actions were taken. The MA's validation review includes an assessment and review of the internal controls established by the OA. The MA assesses the appropriateness of established controls and performs tests to provide reasonable assurance that the established controls are followed. The MA uses the data warehouse to verify that claiming errors were corrected by crediting CMS with any applicable FFP. As a result of the validation review, the MA works with the OA to modify and strengthen internal controls as needed.

## 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 Assurance:**

*The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

**i. Sub-Assurances:**

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)**

**Performance Measures**

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

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

**Performance Measure:**

**I1 Number and percent of reviewed waiver service claims submitted for FFP that are specified in the participant's service plan. Numerator: Number of claims reviewed that were specified in the ISP. Denominator: Number of claims sampled.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Comparison of claims submitted for FFP with service plans**

| <b>Responsible Party for data collection/generation</b><br>(check each that applies): | <b>Frequency of data collection/generation</b><br>(check each that applies): | <b>Sampling Approach</b><br>(check each that applies):                                 |
|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> State Medicaid Agency                                        | <input type="checkbox"/> Weekly                                              | <input type="checkbox"/> 100% Review                                                   |
| <input checked="" type="checkbox"/> Operating Agency                                  | <input type="checkbox"/> Monthly                                             | <input checked="" type="checkbox"/> Less than 100% Review                              |
| <input type="checkbox"/> Sub-State Entity                                             | <input type="checkbox"/> Quarterly                                           | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95% |
| <input type="checkbox"/> Other<br>Specify:                                            | <input checked="" type="checkbox"/> Annually                                 | <input type="checkbox"/> Stratified<br>Describe Group:                                 |

|  |                                                                           |                                                                           |
|--|---------------------------------------------------------------------------|---------------------------------------------------------------------------|
|  |                                                                           |                                                                           |
|  | <input type="checkbox"/> <b>Continuously and Ongoing</b>                  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |
|  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |                                                                           |

**Data Aggregation and Analysis:**

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

**Performance Measure:**

**I2 Number and percent of waiver service claims reviewed that were submitted for participants who were Medicaid Waiver eligible on the date that the service was delivered. Numerator: Number of claims submitted for participants who were Medicaid Waiver eligible on the date the service was provided. Denominator: All waiver claims.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Comparison of claims with enrollment data or database**

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

|                                                                           |                                                                           |                                                                                                        |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
|                                                                           |                                                                           | <b>Review</b>                                                                                          |
| <input type="checkbox"/> <b>Sub-State Entity</b>                          | <input type="checkbox"/> <b>Quarterly</b>                                 | <input type="checkbox"/> <b>Representative Sample</b><br>Confidence Interval =<br><input type="text"/> |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> <b>Annually</b>                       | <input type="checkbox"/> <b>Stratified</b><br>Describe Group:<br><input type="text"/>                  |
|                                                                           | <input type="checkbox"/> <b>Continuously and Ongoing</b>                  | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>                              |
|                                                                           | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |                                                                                                        |

**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"/> <b>State Medicaid Agency</b>                      | <input type="checkbox"/> <b>Weekly</b>                                      |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>                           | <input type="checkbox"/> <b>Monthly</b>                                     |
| <input type="checkbox"/> <b>Sub-State Entity</b>                                      | <input type="checkbox"/> <b>Quarterly</b>                                   |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>             | <input checked="" type="checkbox"/> <b>Annually</b>                         |
|                                                                                       | <input type="checkbox"/> <b>Continuously and Ongoing</b>                    |
|                                                                                       | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/>   |

- b. **Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

**Performance Measures**

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

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

**Performance Measure:**

**I3 Number and percent of waiver claims reviewed that were submitted using the correct rate as specified in the approved waiver application. Numerator: Number of claims with correct rate. Denominator: All claims reviewed in representative sample.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

| <b>Responsible Party for data collection/generation</b><br><i>(check each that applies):</i> | <b>Frequency of data collection/generation</b><br><i>(check each that applies):</i> | <b>Sampling Approach</b><br><i>(check each that applies):</i>                          |
|----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|
| <input type="checkbox"/> State Medicaid Agency                                               | <input type="checkbox"/> Weekly                                                     | <input type="checkbox"/> 100% Review                                                   |
| <input checked="" type="checkbox"/> Operating Agency                                         | <input type="checkbox"/> Monthly                                                    | <input checked="" type="checkbox"/> Less than 100% Review                              |
| <input type="checkbox"/> Sub-State Entity                                                    | <input type="checkbox"/> Quarterly                                                  | <input checked="" type="checkbox"/> Representative Sample<br>Confidence Interval = 95% |
| <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                           | <input checked="" type="checkbox"/> Annually                                        | <input type="checkbox"/> Stratified<br>Describe Group:<br><input type="text"/>         |
|                                                                                              | <input type="checkbox"/> Continuously and Ongoing                                   | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                     |
|                                                                                              | <input type="checkbox"/> Other<br>Specify:<br><input type="text"/>                  |                                                                                        |

**Data Aggregation and Analysis:**

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

|                                                                           |                                                                           |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> <b>Sub-State Entity</b>                          | <input type="checkbox"/> <b>Quarterly</b>                                 |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> <b>Annually</b>                       |
|                                                                           | <input type="checkbox"/> <b>Continuously and Ongoing</b>                  |
|                                                                           | <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> |

- 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 Operating Agency annually conducts a statistically valid review of Waiver claims to ensure the appropriate waiver reimbursement methodology was used and that it was applied correctly.

The Operating Agency also annually conducts a statistically valid review of Waiver participants to ensure the participant was Medicaid eligible on the date of service and that services were actually delivered. These desk reviews can include documentation reviews of eligibility assessments, attendance records, work logs, phone logs, travel logs, appointment schedules, progress notes, etc. If needed, phone interviews with guardians and providers may be included.

**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 findings 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)**

| <b>Responsible Party</b> (check each that applies):                       | <b>Frequency of data aggregation and analysis</b><br>(check each that applies): |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> <b>State Medicaid Agency</b>          | <input type="checkbox"/> <b>Weekly</b>                                          |
| <input checked="" type="checkbox"/> <b>Operating Agency</b>               | <input type="checkbox"/> <b>Monthly</b>                                         |
| <input type="checkbox"/> <b>Sub-State Entity</b>                          | <input checked="" type="checkbox"/> <b>Quarterly</b>                            |
| <input type="checkbox"/> <b>Other</b><br>Specify:<br><input type="text"/> | <input checked="" type="checkbox"/> <b>Annually</b>                             |
|                                                                           | <input type="checkbox"/> <b>Continuously and Ongoing</b>                        |
|                                                                           | <input type="checkbox"/> <b>Other</b><br>Specify:                               |

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**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.

|  |                                                                                     |
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## 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).

The rate setting method for each service category is as follows:

**Residential Habilitation.** Residential Habilitation rates are governed by 89 Ill. Admin. Code, Subchapter c, part 356 available at <http://ilga.gov/commission/jcar/admincode/089/08900356sections.html>. A provider-specific, cost-based prospective per diem rate is calculated for each new provider based on budgeted costs for new programs. Rates are then based on audited historical costs, reported to the State on the Consolidated Financial Report after the first year of operation. Rates may also be adjusted as described in Part 356.70:

Increases in reimbursable cost can be granted by the Department for the following reasons and in the following categories:

- 1) Mechanical or clerical errors were committed by the Department.
- 2) There has been a substantial decrease in external government grants which the Department determines seriously limits the ability of the agency to deliver required services to Department clients, to the extent that such revenues were considered available when the Department approved the reimbursable cost of the provider.
- 3) The Agency was able to document and justify that the Department's treatment of its historical cost data resulted in an inequitable application of the rate-setting process.
- 4) Mechanical or clerical errors were committed by the provider on required cost reports and used by the Department in the calculation of reimbursable costs.

The State establishes a claiming rate to correspond with the Residential Habilitation payment rate. While the State includes a room and board component in its payment method, all room and board components are excluded from the amount claimed for Medicaid matching funds.

**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 statewide rate levels for this service based on provider

qualifications. Both levels reflect standard, hourly, fee-for-service rates. The Level I rate is based on a weighted combination of Bureau of Labor Statistics wages for licensed clinical psychologists, provider survey results and a comparison to bargaining agreement wages for state employees. The rate includes fringe benefit costs, administrative overhead and assumptions about billable hours. The Level II rate is set at 80% of the Level I rate. The 80% adjustment factor is based on observations from other behavioral health programs with similar rate differentials and recognizes the different level of education, training and experience for Behavior Consultant Level II.

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.

The fee-for-service schedule that includes Information about payment rates for all Waiver services is available at <http://www.dhs.state.il.us/page.aspx?item=38992>.

- 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 feeds into the computerized claiming system that contains edits to ensure that the participant has been determined to meet the ICF/IDD 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 habilitation 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 habilitation 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-centered service 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.

The Operating Agency annually conducts a statistically valid review of Waiver claims to ensure the appropriate waiver reimbursement methodology was used and that it was applied correctly.

The Operating Agency also annually conducts a statistically valid review of Waiver participants to ensure the participant was Medicaid eligible on the date of service and that services were actually delivered. These desk reviews can include documentation reviews of eligibility assessments, attendance records, work logs, phone logs, travel logs, appointment schedules, progress notes, etc. If needed, phone interviews with guardians and providers may be

included.

- 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.**

**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:

## 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.**
- This waiver is a part of a concurrent 1115/1915(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 1115 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:

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## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: ICF/IID**

| Col. 1 | Col. 2   | Col. 3    | Col. 4      | Col. 5   | Col. 6    | Col. 7      | Col. 8                          |
|--------|----------|-----------|-------------|----------|-----------|-------------|---------------------------------|
| Year   | Factor D | Factor D' | Total: D+D' | Factor G | Factor G' | Total: G+G' | Difference (Col 7 less Column4) |
| 1      | 80604.00 | 5678.00   | 86282.00    | 89071.14 | 2821.24   | 91892.38    | 5610.38                         |
| 2      | 80604.00 | 5778.00   | 86382.00    | 89961.85 | 2849.45   | 92811.30    | 6429.30                         |
| 3      | 80604.00 | 5880.00   | 86484.00    | 90861.47 | 2877.95   | 93739.42    | 7255.42                         |
| 4      | 80604.00 | 5984.00   | 86588.00    | 91770.09 | 2906.73   | 94676.82    | 8088.82                         |
| 5      | 80604.00 | 6090.00   | 86694.00    | 92687.79 | 2935.79   | 95623.58    | 8929.58                         |

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

| Waiver Year | Total Unduplicated Number of Participants (from Item B-3-a) | Distribution of Unduplicated Participants by Level of Care (if applicable) |     |
|-------------|-------------------------------------------------------------|----------------------------------------------------------------------------|-----|
|             |                                                             | Level of Care:                                                             |     |
|             |                                                             | ICF/IID                                                                    |     |
| Year 1      | 295                                                         |                                                                            | 295 |
| Year 2      | 295                                                         |                                                                            | 295 |
| Year 3      | 295                                                         |                                                                            | 295 |
| Year 4      | 295                                                         |                                                                            | 295 |
| Year 5      | 295                                                         |                                                                            | 295 |

## 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 the CMS 372 reports and current data. Due to the small size of this waiver, the ALOS can fluctuate from year to year.

## 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 a historical average percent of change, comprised of rate increases and case mix changes of current utilization and costs among children enrolled in the Children's Residential Waiver. Factor D is based on analysis of data for FY2010 through FY2014 (estimated) costs for children who received waiver services in a Child Group Home. For each year, the next change varied from a positive 4% to a negative 3%, with one year appearing to be an anomaly with a 16% increase. Consequently, in estimating projections for the next five years, the year in which the 16% increased occurred, is being excluded in the analysis of the past five year trend. The result of the calculations trends a modest 1% increase above the Waiver Year 4 level.

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 FY2011 through FY2015 (estimated) Medicaid ancillary costs for children who would be receiving waiver services in a home environment. The 1.77% increase is based upon the historical average percent of change, which is comprised of rate increases and case mix changes for FY2011 through FY2015 (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 FY2010 through– FY2014 (estimated) and includes data for all age groups. Factor G estimated for FY2011 through – FY2015 is based upon historical percent changes trended forward for all years. The average historical percent change was less than 1%.

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 FY2010 – FY2014 (estimated). The data incorporates individuals of all age groups. Factor G' estimated for FY2011 through – 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  |
|----------------------------------------------------|----------|---------|---------------------|-----------------|----------------|-------------|
| <b>Child Group Home Total:</b>                     |          |         |                     |                 |                | 23502650.00 |
| Child Group Home                                   | Day      | 295     | 310.00              | 257.00          | 23502650.00    |             |
| <b>Adaptive Equipment Total:</b>                   |          |         |                     |                 |                | 1000.00     |
| Adaptive Equipment                                 | Per Item | 10      | 1.00                | 100.00          | 1000.00        |             |
| <b>Assistive Technology Total:</b>                 |          |         |                     |                 |                | 2500.00     |
| Assistive Technology                               | Per Item | 10      | 1.00                | 250.00          | 2500.00        |             |
| <b>Behavior Intervention and Treatment Total:</b>  |          |         |                     |                 |                | 271950.00   |
| Behavior Intervention                              | Hour     | 185     | 21.00               | 70.00           | 271950.00      |             |
| <b>GRAND TOTAL:</b>                                |          |         |                     |                 |                | 23778100.00 |
| Total Estimated Unduplicated Participants:         |          |         |                     |                 |                | 295         |
| Factor D (Divide total by number of participants): |          |         |                     |                 |                | 80604.00    |
| Average Length of Stay on the Waiver:              |          |         |                     |                 |                | 310         |

**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  |
|------------------------------------|----------|---------|---------------------|-----------------|----------------|-------------|
| <b>Child Group Home Total:</b>     |          |         |                     |                 |                | 23502650.00 |
| Child Group Home                   | Day      | 295     | 310.00              | 257.00          | 23502650.00    |             |
| <b>Adaptive Equipment Total:</b>   |          |         |                     |                 |                | 1000.00     |
| Adaptive Equipment                 | Per Item | 10      | 1.00                | 100.00          | 1000.00        |             |
| <b>Assistive Technology Total:</b> |          |         |                     |                 |                | 2500.00     |
| Assistive Technology               | Per Item | 10      | 1.00                | 250.00          | 2500.00        |             |
| <b>Behavior Intervention and</b>   |          |         |                     |                 |                |             |

|                                                    |      |     |       |       |           |             |
|----------------------------------------------------|------|-----|-------|-------|-----------|-------------|
| <b>Treatment Total:</b>                            |      |     |       |       |           | 271950.00   |
| Behavior Intervention                              | Hour | 185 | 21.00 | 70.00 | 271950.00 |             |
| <b>GRAND TOTAL:</b>                                |      |     |       |       |           | 23778100.00 |
| Total Estimated Unduplicated Participants:         |      |     |       |       |           | 295         |
| Factor D (Divide total by number of participants): |      |     |       |       |           | 80604.00    |
| Average Length of Stay on the Waiver:              |      |     |       |       |           | 310         |

## 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  |
|----------------------------------------------------|----------|---------|---------------------|-----------------|----------------|-------------|
| <b>Child Group Home Total:</b>                     |          |         |                     |                 |                | 23502650.00 |
| Child Group Home                                   | Day      | 295     | 310.00              | 257.00          | 23502650.00    |             |
| <b>Adaptive Equipment Total:</b>                   |          |         |                     |                 |                | 1000.00     |
| Adaptive Equipment                                 | Per Item | 10      | 1.00                | 100.00          | 1000.00        |             |
| <b>Assistive Technology Total:</b>                 |          |         |                     |                 |                | 2500.00     |
| Assistive Technology                               | Per Item | 10      | 1.00                | 250.00          | 2500.00        |             |
| <b>Behavior Intervention and Treatment Total:</b>  |          |         |                     |                 |                | 271950.00   |
| Behavior Intervention                              | Hour     | 185     | 21.00               | 70.00           | 271950.00      |             |
| <b>GRAND TOTAL:</b>                                |          |         |                     |                 |                | 23778100.00 |
| Total Estimated Unduplicated Participants:         |          |         |                     |                 |                | 295         |
| Factor D (Divide total by number of participants): |          |         |                     |                 |                | 80604.00    |
| Average Length of Stay on the Waiver:              |          |         |                     |                 |                | 310         |

## 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  |
|----------------------------------------------------|----------|---------|---------------------|-----------------|----------------|-------------|
| <b>Child Group Home Total:</b>                     |          |         |                     |                 |                | 23502650.00 |
| Child Group Home                                   | Day      | 295     | 310.00              | 257.00          | 23502650.00    |             |
| <b>Adaptive Equipment Total:</b>                   |          |         |                     |                 |                | 1000.00     |
| Adaptive Equipment                                 | Per Item | 10      | 1.00                | 100.00          | 1000.00        |             |
| <b>Assistive Technology Total:</b>                 |          |         |                     |                 |                | 2500.00     |
| Assistive Technology                               | Per Item | 10      | 1.00                | 250.00          | 2500.00        |             |
| <b>Behavior Intervention and Treatment Total:</b>  |          |         |                     |                 |                | 271950.00   |
| Behavior Intervention                              | Hour     | 185     | 21.00               | 70.00           | 271950.00      |             |
| <b>GRAND TOTAL:</b>                                |          |         |                     |                 |                | 23778100.00 |
| Total Estimated Unduplicated Participants:         |          |         |                     |                 |                | 295         |
| Factor D (Divide total by number of participants): |          |         |                     |                 |                | 80604.00    |
| Average Length of Stay on the Waiver:              |          |         |                     |                 |                | 310         |

## 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  |
|----------------------------------------------------|----------|---------|---------------------|-----------------|----------------|-------------|
| <b>Child Group Home Total:</b>                     |          |         |                     |                 |                | 23502650.00 |
| Child Group Home                                   | Day      | 295     | 310.00              | 257.00          | 23502650.00    |             |
| <b>Adaptive Equipment Total:</b>                   |          |         |                     |                 |                | 1000.00     |
| Adaptive Equipment                                 | Per Item | 10      | 1.00                | 100.00          | 1000.00        |             |
| <b>Assistive Technology Total:</b>                 |          |         |                     |                 |                | 2500.00     |
| Assistive Technology                               | Per Item | 10      | 1.00                | 250.00          | 2500.00        |             |
| <b>Behavior Intervention and Treatment Total:</b>  |          |         |                     |                 |                | 271950.00   |
| Behavior Intervention                              | Hour     | 185     | 21.00               | 70.00           | 271950.00      |             |
| <b>GRAND TOTAL:</b>                                |          |         |                     |                 |                | 23778100.00 |
| Total Estimated Unduplicated Participants:         |          |         |                     |                 |                | 295         |
| Factor D (Divide total by number of participants): |          |         |                     |                 |                | 80604.00    |
| Average Length of Stay on the Waiver:              |          |         |                     |                 |                | 310         |