

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

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

This 1915 (c) Waiver for Adults with Developmental Disabilities renewal includes:

1) Inclusion of Performance Measures to be consistent with federal changes in assurances and sub-assurances. Performance measures are also being modified to be consistent with changes made as part of the renewals of the two DD Children's Waivers operated in Illinois.

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. Subsequent revisions to the Transition Plan have been submitted on February 29, 2016 and February 1, 2017.

3) Modifications to processes related to Participant Centered Planning in accordance with HCBS final rules (2249-F and 2296-F) published on January 16, 2014 impacting this 1915c Medicaid waiver and enable waiver participants to direct the planning process. This would allow a representative(s) whom the individual has freely chosen and would result in a person-centered plan with individually identified goals and preferences. The PCP would also have promote 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.

4) The Information and Assistance in Support of Participant Direction (formerly Service Facilitation) definition in Appendix C for the Home-Based Support Services option is being modified to remove the requirement that everyone in this option receive two hours of this service per month. This service is now optional and focused on assistance to participants and their families in managing their self-directed services.

5) The day habilitation and supported employment definitions in Appendix C are being modified to provide more integration for site-based services and enhance access to supported employment. Further, a new day option is being added in Appendix C that will afford participants the opportunity to receive services in small groups in community environments during the day.

6) Program capacity is being increased as part of the renewal.

A waiver renewal notice was sent to the tribal government on February 10, 2017.

In accordance with these substantive changes, this waiver was posted on February 9, 2017 at the website of the Illinois Department of Healthcare and Family Services (HFS), <http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx>. The posting for public comment ran until March 10, 2017. A second public comment period was held from May 31, 2017 to June 30, 2017.

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

HCBS Waiver for Adults with Developmental Disabilities

C. Type of Request: 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.0350

Waiver Number: IL.0350.R04.00

Draft ID: IL.026.04.00

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

Regular Waiver 

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

07/01/17

Approved Effective Date: 12/11/17

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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



Inpatient psychiatric facility for individuals age 21 and under as provided 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:

Not applicable.

1. Request Information (3 of 3)

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

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual 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

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

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

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

Participants who choose home-based supports may select from a menu of services based on their individual needs within an overall monthly services cost maximum. Typical services chosen by participants may include day programs as well as personal support services provided by domestic employees or by employees of direct service providers. When participants exercise employer authority and hire domestic employees, the services of a Financial Management Services (FMS) entity

are available. Participants also have a variety of therapies and other services available to them.

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

All participants receive assistance in directing service delivery options from Independent Service Coordination (ISC) entities under contract with the Operating Agency.

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

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

3. Components of the Waiver Request

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

- A. **Waiver Administration and Operation. Appendix A** specifies the administrative and operational structure of this waiver.
- B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. **Participant Services. Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. **Participant-Centered Service Planning and Delivery. Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- Yes. This waiver provides participant direction opportunities. Appendix E is required.**
 - No. This waiver does not provide participant direction opportunities. Appendix E is not required.**
- F. **Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. **Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. **Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.
- I. **Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. **Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan

to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

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

Not Applicable

No

Yes

C. Statewideness. Indicate whether the State requests a waiver of the 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

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

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

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

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

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

based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver: Illinois secured public input into the development of this waiver through 2 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 2 methods of public notification, the dates of the 30 day public input period were identified. The 30 day public period is from 5/29/15 - 6/28/15.

In addition to these 2 methods of notification, the OA 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; 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.

The State gathered public input for this Waiver Renewal in several ways. The public comment period started on Tuesday, February 9, 2017, and concluded on Thursday, March 10, 2017. Second, on February 9, 2017 the Medicaid Agency posted on its public website a draft of the proposed Waiver Renewal. The draft Waiver Renewal will stay on the public website until final approval of the Renewal from CMS.

Finally, the State issued notice to allow for tribal notification on February 10, 2017.

The State received 119 public comments during the public comment period with 8 additional comments received after the end of the comment period. The State did not receive any comments during the tribal notice period. The State received 149 comments during the comment period with 7 additional comments being received after the end of the second comment period.

The Waiver Renewal applications are located at the following active link:

<https://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/default.aspx>. In addition, the Illinois Department of Healthcare and Family Services (HFS) posts all Waiver Renewals on its website. Lastly, anyone can request a hard copy of the entire waiver by calling a number listed on the notice. The public notice invited comments via email or mail.

For additional public comments please see section: Main B. Optional

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

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

7. Contact Person(s)

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

Last Name:

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:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Illinois**

Zip:

Phone:

(217) 552-4139

Ext: TTY**Fax:**

(217) 558-2799

E-mail:

Stephanie.Leach@illinois.gov

8. Authorizing Signature

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

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

Signature:

Kelly Cunningham

State Medicaid Director or Designee

Submission Date:

Dec 7, 2017

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

Last Name:

Hursey

First Name:

Teresa

Title:

Acting Medicaid Director

Agency:

Healthcare and Family Services

Address:

201 South Grand Avenue East

Address 2:**City:**

Springfield

State:

Illinois

Zip:

62763

Phone:

(217) 782-5672

Ext: TTY

Fax:

(217) 782-5672

E-mail:

Attachments

teresa.hursey@illinois.gov

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:

As a condition of approval for the Adults with Developmental Disabilities waiver (effective date of July 1, 2017), it was determined that a CAP should be implemented for Administrative Authority and Health and Welfare. The CAP was approved 12/06/2017 and expected to be fully implemented by 12/31/18.

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

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

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

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

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

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

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. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

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.

Based upon follow-up site validation visits to provider settings, the State agencies under whose jurisdiction these settings operate along with HFS, are in the process of notifying 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 has made recommendations as to whether certain Illinois' HCBS settings qualify for "Heightened Scrutiny".

The State is working 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.

The first Statewide Transition Plan was submitted to federal CMS on March 16, 2015. After receiving guidance from CMS, subsequent revisions to the plan have been submitted on February 29, 2016 and February 1, 2017.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

In accordance with federal regulations, the Medicaid and Operating agencies sought public comment on the proposed renewal application. The draft application was posted on February 9, 2017, at the website of the Medicaid Agency, the Illinois Department of Healthcare and Family Services (HFS), at <https://www.illinois.gov/hfs/SiteCollectionDocuments/ADULTDDrenewal02092017.pdf>.

The posting for public comment ran through March 10, 2017. Additional comments were received through March 16, 2017 and those comments were included for response.

A second public notice period was conducted from May 31, 2017 to June 30, 2017.

Interested parties were given two means through which to submit public comments:

Comments could be submitted via e-mail to HFS.HCBSWaiver@illinois.gov, or in writing to:

Illinois Department of Healthcare and Family Services
Attention: Waiver Manager
201 S. Grand Avenue East, 2nd Floor
Springfield, IL 62763

The Operating Agency also posted the draft on its website at <http://www.dhs.state.il.us/page.aspx?item=45915>. In addition, it shared the link and an overview of significant changes with its major trade and advocacy organizations, encouraging them to review the draft and participate in the public comment period. These organizations in turn shared the information with their members. The Operating Agency also included an item about the draft application and public comment period in the February 17, 2017, edition of its newsletter to stakeholders.

A total of 119 commenters responded with input during the public comment period and 8 additional comments were

received after the comment period had ended for a total of 127 separate comments. The key points and the State's response to each are listed below. Please note that many individual comments that were received had multiple points and that numerous people responded multiple times.

Issue: One contact per year by the Independent Service Coordination (ISC) agency is not enough. This issue was noted on 25 received public comments.

Response: The State modified language in the Waiver to clarify a minimum of two separate direct, in-person contacts are required for the ISC per year. One is for plan development; the other is to monitor the plan's implementation. Additional contacts will be made based on the needs and preferences of the Waiver participant.

Issue: ISC agencies indicate the proposed plan template and processes take more hours than are supported by the current fee-for-service payment structure for this administrative activity. This issue was noted on 16 received public comments.

Response: The draft template and processes have been tested by ISC agencies. A workgroup is now revising the documents based on the feedback received to ensure compliance with Federal and State regulations and to provide for as much efficiency as possible. The new format and processes will be finalized and implemented by July 1, 2017. The current Waiver indicates that ISC agencies will have contact with all Waiver Participants a minimum of four times per year. The renewal application changes that to a minimum of one visit per year in the home in addition to the time spent with the individual and guardian during the assessment and planning processes, for a total minimum contact of two per year. Additional contact will be determined by the needs of the individual, per guidelines issued by the Operating Agency. We believe this change will give ISC agencies the flexibility to direct their resources based on the needs of the Participants at a given point in time.

Issue: The current Waiver states the maximum number of billable hours for Employment and Day services is 1,100 per year. This maximum is based on the requirement that Developmental Training sites be open for services a minimum of five hours per day for 240 days per year, or a total of 1,200 per year. The State then calculated the hourly rate with an absentee factor so that the 1,200 per year could be billed in 1,100 hours. The State proposes changing the methodology to allow for billing of 1,200 hours per year. Some providers objected to this change indicating they would lose funding due to absenteeism and others identified a potential loss of revenue to the system due to a rounding issue. This issue was noted on 61 received public comments.

Response: The State intends to follow through with this proposed change. While this practice has been in place for decades now, it continues to cause confusion for stakeholders as to the number of service hours that are actually calculated into the annual funding amount. While the hourly rate will be reduced to accommodate this change, the annual amount of funding will remain constant, but providers' revenue will reflect actual attendance. In addition to simplifying the methodology, we believe this change will make it easier for Participants to develop Plans that incorporate multiple types of Employment and Day services. The full 1200 hours must be available to Participants so they can choose among all types of day programs, including employment related services. The State has addressed the rounding issue and will ensure no funds are lost to the system.

Issue: Commenters indicate that the rates paid under the Waiver programs are too low, specifically citing provider wages for Direct Support Persons. This issue was noted on 97 received public comments.

Response: The State is aware of stakeholder concerns regarding wages for Direct Support Persons in residential and day programs. This issue continues to be discussed as part of the State's budgetary negotiations. The renewal application reflects estimated average costs to the State as allowed by current spending authority. Current spending levels have been sufficient to sustain growth in the Waiver, as reflected by the requested increase in capacity, and development of new residential sites.

Issue: Commenters liked the addition of the new Community Access/Pathways to Employment Service. This issue was noted on 34 received public comments.

Response: No response needed.

Issue: The State is undergoing a change in its case management functions for the self-directed Home-Based Support Services Program. Commenters asked questions regarding the role of the ISCs compared to the functions of the Information

and Assistance in Support of Participant Direction service (formerly called Service Facilitation).

This issue was noted on 10 received public comments.

Response: The State is in the midst of sharing information about the changes, making documents available on its website and informing families through the Independent Service Coordination agencies.

Issue: The State is proposing to add a new service to assist providers serving Participants with exceptionally challenging behavior issues regarding property destruction. The State proposed the new service be limited to individuals with two previous psychiatric administrations. Commenters felt this was too limiting.

This issues was noted on 30 received public comments.

Response: The State has modified the language to indicate the service would be limited to individuals who have extreme behavior issues as evidenced by a functional analysis of property destruction by a qualified behavior therapist under this Waiver per guidelines issued by the OA. Prior approval must coincide with the development of a behavior intervention strategy to address this behavior.

Issue: Family members providing comment on the revised definition of Supported Employment-Individual reviewed the language as limiting their options for providers of service.

This issue was noted on 4 public comments.

Response: In C-1/C-3, the State modified the definition of Individualized Supported Employment to remove language restricting and discouraging providers of Supported Employment services from also being the employer of record. We have maintained the Medicaid free-choice-of-provider requirement to be able to choose a different provider of Supported Employment-Individual services without jeopardizing their continued employment.

Issue: In C-1/C-3, family members providing comment on the revised definition of site-based Developmental Supports thought that language in the last paragraph was confusing as to whether individuals are required to participate in other types of day programs.

This issue was noted on 3 public comments.

Response: The word “expected” was changed to “encouraged”. The phrase, “consistent with individual’s informed choice” was added to the end of the last sentence for clarity.

Issue: A commenter indicated that some quality assurance review findings are corrected immediately rather than through a plan of correction.

This issue was noted on 1 public comment.

Response: The State added clarifying language to reflect that some findings are corrected immediately while reviewers are on site rather than through a plan of correction.

Issue: A commenter identified a few remaining references to mental retardation and suggested the requirement of the need for active treatment be removed from the eligibility criteria.

This issue was noted on 1 public comment.

Response: The references to mental retardation have been corrected. The need for active treatment under the eligibility criteria has been replaced with the need for ICF/IDD level of care.

Issue: Several commenters noted confusion in the language as to the entity responsible for conducting risk assessments.

This issue was noted on 6 public comments.

Response: The State clarified this language.

Issue: Commenters pointed out the need for various technical corrections.

This issue was noted on 30 public comments.

Response: The State has made the needed changes.

During the second Public Notice period (May 31, 2017 to June 30, 2017), A total of 149 commenters responded with input during the public comment period and 7 additional comments were received after the comment period had ended for a total of 156 separate comments. The key points and the State’s response to each are listed below. Please note that many

individual comments that were received had multiple points and that numerous people responded multiple times.

Issue: Commenters proposed utilizing people with IDD to expand the DSP workforce. (14 Comments)

Response: Currently, there is nothing in the Waiver that prevents this as long as the individual is able to meet the provider qualifications.

Issue: Commenters proposed that there are not enough contacts by the ISC and that they had concerns with the roles and functions of the ISC's. (3 Comments)

Response: The Waiver indicates that one ISC contact is for plan development and the other is to monitor the plan's implementation. Additional contact will be made based on the needs and preferences of the Waiver participants. In addition, ISC case management functions are aligned with federal CMS expectations.

Issue: Commenter showed concern about implementing the Person Centered Plan and concerns of the provider's role. (10 comments)

Response: The State asks that the agencies do their best that they can as we look at identified needs or lack of needs during the transition period to person centered planning. The providers can contact the State and the State will track and assist. Participants need to be able to explore their options using person centered planning.

Issue: Commenters proposed more flexible and supportive housing as an option. (14 comments)

Response: The State currently has Waiver participants who are in supportive housing and supports it as an option for Wavier participants to consider.

Issue: Commenters indicated that the rates paid under the Waiver are too low, specifically citing provider wages for Direct Support Persons. (54 Comments)

Response: The State is award of stakeholder concerns regarding wages for DSP's in residential and day programs. The State has implemented a \$.75 wage increase and has reflected those rates in the current re renewal application.

Issue: Commenters showed concern over the sit-based DT rate going from \$10.39 in the approved Waiver to \$9.53 in the pending application. (126 comments)

Response: The State has changed the pending renewal application addressing the rate issue by combining the Site-based DT and Community Access into Community Day Services. The 10.39 rate will be paid for Community Day Services (that is not including the increase which brings it to \$10.88)

Issue: Commenters showed concern over the State giving individuals who wish to be in Day Programs the flexibility of using 1200 hours combined for the Day Program options instead of having 1100 hours as in the currently approved Waiver. (27 comments)

Response: The State has adjusted the Application back to 1100 hours as a cap for all Day Programs.

Appendix A: Waiver Administration and Operation

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

- The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

Illinois Department of Human Services (DHS), Division of Developmental Disabilities

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

There is an interagency agreement in place between Medicaid Agency (MA) and Operating Agency (OA) that describes the roles and responsibilities of each agency with respect to the waiver. The interagency agreement is reviewed annually and amended if necessary.

The MA delegates the day-to-day operations of this waiver to Illinois Department of Human Services (DHS), Division of Developmental Disabilities as the OA. The OA consults the MA waiver manager, or other designated MA staff, about all waiver rule and policy changes before submission to the MA Medical Policy Review Committee.

The MA's Medical Policy Review Committee reviews all waiver rule and policy changes. All waiver policy and rule changes must be approved by the MA's Medical Policy Review Committee before implementation. The OA primary responsibilities are the day-to-day care coordination and quality assurance activities with respect to the waiver.

The OA delegated responsibilities include: budgeting, determination of participant eligibility, person centered plan development, provide technical assistance to providers to enroll in Medicaid, ensuring service plans are implemented, and ensuring services and providers meet standards established in the approved waiver and governing rules.

The MA enrolls providers in Medicaid, processes federal claims, and maintains an appeal process.

The MA conducts all waiver appeal hearings and issues final determination decisions. The MA does not delegate this function to the OA. The MA provides independent, trained hearing officers for all appeal hearings.

The MA provides the OA data, reports, or information as may be required to ensure compliance with State and Federal licensure and certification requirements and quality monitoring responsibilities.

The MA and OA both conduct routine oversight and monitoring activities to ensure the State meets fiscal assurances and accountability of the waiver.

The MA reviews and approves changes to the OA's payment rate and methodologies.

The MA consults with OA in the development of monitoring protocols with respect to the waiver. All monitoring protocols and tools must be introduced at quarterly meetings and approved by the MA.

The OA and MA provide Performance Measure (PM) reports quarterly and annually. These reports include information on remediation activities. The OA and MA jointly review and analyze these reports.

The OA provides reports on remediation of identified issues quarterly and annually. The OA and MA jointly review and analyze these reports.

The MA receives all death reports from the OA.

The MA receives all reports of terminated and sanctioned providers from the OA.

The MA and OA meet no fewer than two times quarterly to review policy, provider compliance, and client safety and welfare.

The MA participates with the OA, or makes reasonable effort to attend, in training and informational sessions as necessary.

The MA attends, or makes reasonable effort to attend, the OA's salient internal meetings with agency stakeholders and other pertinent parties

MA and OA staff communicate regularly regarding any issues that arise relating to administration of the waiver. These topics include general waiver administration, quality improvement strategies, HCBS Rule transition, etc. with respect to the waiver.

Annually, the MA conducts select reviews, including eight independent monitoring reviews as part of MA oversight

Annually, the MA participates jointly with the OA in select targeted reviews of a representative sample of participants, and by using performance measures and sampling described in Appendix A.

The OA provides the MA copies of the written reports of all substantiated Abuse, Neglect, and Financial Exploitation findings .

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

The Medicaid Agency, with cooperation and direction from CMS, has developed an Administrative Authority Corrective Action Plan to address Health and Welfare issues within the administration of this waiver.

Appendix A: Waiver Administration and Operation

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

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Independent Service Coordination (ISC) entities under contract with the Operating Agency, complete eligibility determinations, conduct monitoring functions and provide independent service coordination. These functions are done by Qualified Intellectual Disabilities Professionals (QIDPs).

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

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

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

Appendix A: Waiver Administration and Operation

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

- Not applicable**
- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
 - Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

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

Appendix A: Waiver Administration and Operation

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

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

Following each review, the ISC entities are notified by the Operating Agency in writing at the time of exit of any findings and are required to submit a corrective action plan, including timeframes for correction, for all findings that cannot be corrected immediately while the reviewers are on site. Providers must submit the corrective action plan to the OA within 14 calendar days of the exit and are required to develop a plan that will correct all findings, other than those corrected immediately while the reviewers are on site, within 60 calendar days. In instances of serious findings which raise concerns regarding a participant's health, safety or welfare, the provider may be directed by the OA to correct a finding in a much shorter timeframe, including instances of immediate correction, where appropriate. Operating Agency staff review the corrective action plan and, if acceptable, approve it within 14 calendar days of receipt. If a corrective action plan is determined by the OA to be unacceptable, the provider is contacted and the problem(s) are explained. The OA works with the provider to develop an acceptable corrective action plan. In cases where the provider fails to submit a corrective action plan within the required timeframes

and/or when the provider fails to submit an acceptable plan (following assistance from the OA), the OA develops and imposes a mandatory corrective action plan.

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

The MA will provide oversight to the OA in monitoring assessments through numerous methods. 1. The OA conducts quarterly and annual reviews of the assessment process. The initial assessment is rarely not completed in a timely manner because without the assessment, payment is withheld. The OA posts this data for public transparency. The link to the OA's website is located here: <http://www.dhs.state.il.us/page.aspx?item=97777> The MA reviews this data at quarterly waiver meetings. If trends are identified that reveal noncompliance, an action plan to ensure compliance is implemented. 2. In addition to the OA assessment review and MA oversight, the contracted Quality Improvement Organization reviews a sample of records to ensure compliance. These reports are shared with the Waiver Quality Management team. If noncompliance is identified, an action plan would be developed to address the issue.

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 OA. N: Number of rate changes approved by the MA prior to implementation by the OA. D: Total number of rate methodology changes adopted.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation <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 checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	
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Data Aggregation and Analysis:

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

Performance Measure:

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

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<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 Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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. N: Number of participant reviews conducted by the OA according to the sampling methodology in the waiver. D: Total number of participant reviews required according to the sampling methodology.

Data Source (Select one):

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

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

Performance Measure:

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

Data Source (Select one):

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

If 'Other' is selected, specify:

OA database

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

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

Performance Measure:

A5 Number and percent of findings of noncompliance in the area of Medicaid Waiver provider agreement on file with the MA with evidence of remediation within 60 days of discovery. N: Number of findings in the area of Waiver provider agreements on file with the MA with evidence of remediation within 60 days. D: Total number of findings in the area of Waiver provider agreements.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MA MMIS

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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 checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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 unannounced 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 quarter. Joint reviews may be conducted by the MA and OA. The MA participates in select 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 individual issues found as issues are discovered. The OA provides standardized summary reports to the MA for its review and oversight.

Depending upon the type of issue, general corrective actions include requiring person centered plan revisions and implementation, retraining staff on individual specific needs, providing technical assistance on specific behavioral or medical issues, consultation with participants/families, increased monitoring of specific individuals/sites/provider, voiding claims, etc.

The summary reports for each Performance Measure document the number and percent of noncompliance findings, the types of remediation taken (including the number of times each remediation type was applied in the event multiple types were used to resolve an issue), and the timeliness of the remediation (i.e., within 30 days, within 60 days, within 90 days, or longer).

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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"/> Aged or Disabled, or Both - General					
	<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"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<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"/> Intellectual Disability or Developmental Disability, or Both					
	<input checked="" type="checkbox"/>	Autism	18	<input type="text"/>	<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Developmental Disability	18	<input type="text"/>	<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Intellectual Disability	18	<input type="text"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<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/IID level of care, must reside within the State of Illinois and not be in need of nursing assessment, monitoring, intervention, and supervision of their condition or needs on a 24-hour basis. The Waiver does not serve individuals who need services solely due to physical conditions, but rather serves individuals with Intellectual Disabilities or conditions similar to Intellectual Disabilities, thus requiring an ICF/IID level of care.

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

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

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Appendix B: Participant Access and Eligibility

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

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

- A level higher than 100% of the institutional average.**

Specify the percentage:

- Other**

Specify:

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

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

- The following dollar amount:**

Specify dollar amount:

The dollar amount (*select one*)

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

Specify the formula:

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

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

Specify percent:

- Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- The participant is referred to another waiver that can accommodate the individual's needs.
- Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

- Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	<input type="text" value="23049"/>
Year 2	<input type="text" value="23049"/>

Waiver Year	Unduplicated Number of Participants
Year 3	23049
Year 4	23049
Year 5	23049

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:

Individuals potentially in need of these services are enrolled in the State's Prioritization of Urgency of Need for Services (PUNS) database by one of the contracted entities serving as access points. This database records demographic and clinical information regarding the individual and his/ her circumstances, services currently received, and services needed. As appropriations are available, individuals are selected for authorization for Waiver services via an automated process that focuses on the individual's needs and the family's circumstances (where applicable). Entrance to the Waiver for Adults with Developmental Disabilities of otherwise eligible applicants is deferred via this process until capacity becomes available as a result of turnover or the appropriation of additional funding by the legislature.

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver**a.****1. State Classification.** The State is a (*select one*):

- §1634 State
- SSI Criteria State
- 209(b) State

2. Miller Trust State.Indicate whether the State is a Miller Trust State (*select one*):

- No
- Yes

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:****Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)***

- Low income families with children as provided in §1931 of the Act
- SSI recipients
- Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- Optional State supplement recipients
- Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- 100% of the Federal poverty level (FPL)
- % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy in 209(b) States (42 CFR §435.330)
- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

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.

Special home and community-based waiver group under 42 CFR §435.217 Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:**

Select one:

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

Specify percentage:

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

Specify dollar amount:

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

Select one:

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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 (2 of 7)

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

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

Answers provided in Appendix B-4 indicate that you do not need to 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:

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

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

Specify:

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

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

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

Specify:

iii. Allowance for the family (select one):

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

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

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

Specify:

- Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-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 re-evaluations are performed by the Independent Service Coordination (ISC) entities under contract with the Operating Agency.

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

Persons making the initial evaluations must be Qualified Intellectual Disabilities Professionals (QIDPs) as defined in Federal ICF/IID regulations.

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

Required assessments and level of care criteria are described fully in the Operating Agency's screening manual for developmental disabilities, which is used by all individuals conducting waiver screening. The manual is available on the Operating Agency's website.

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

For applicants with mental retardation:

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

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

- Physical examination and medical history that documents the diagnosis.

For applicants with Autism:

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

For all applicants:

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

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

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

The MA will provide oversight to the OA of the monitoring of redeterminations of the Level of Care through numerous methods. 1. The OA conducts quarterly and annual reviews of the redetermination process. The OA provides this data on their website for public transparency. The link to the OA's website is located here: <http://www.dhs.state.il.us/page.aspx?item=97777> The MA reviews this data at quarterly waiver meetings. If trends are identified that reveal noncompliance, an action plan would be developed to ensure compliance is achieved. 2. In addition to the OA assessment review and MA oversight, the contracted Quality Improvement Organization reviews a sample of records to ensure compliance. These reports are shared with the Waiver Quality Management team. If noncompliance is identified, an action plan would be developed to address the issue.

- 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.

As part of the initial level of care determination process, staff of the contracted agencies are responsible for performing or arranging for necessary assessments and collecting other needed information to determine level of care. A Qualified Intellectual Disabilities Professional (QIDP) reviews assessment results and other available information against the level of care criteria and guidance in the screening manual for developmental disabilities. The QIDP uses the totality of the information available and best clinical judgment in making the determination. Assessment information and level of care determinations are documented on forms specified by the Operating Agency. Level of care determinations are transmitted electronically to the Operating Agency.

The re-determination process is essentially the same, except the ongoing level of care determination is based on a current ICAP, individual assessments and other information from the person centered planning process in conjunction with personal knowledge of the participant. Level of care re-determinations are documented on a form

specified by the Operating Agency and are transmitted electronically to the Operating Agency.

The OA uses a combination of assessments to determine eligibility, including the ICAP, plus psychological, physical, and psychiatric assessments, as warranted by the individual's related condition(s). The ICAP gathers information on maladaptive behavior index, adaptive behavior index and service score and level. The psychological assessment gathers information on cognitive/intellectual functioning, developmental history, educational background, adaptive skill level, multi-axial diagnosis that includes a primary diagnosis, and recommendations for future service delivery. The physical assessment gathers information on the individual's physical condition that includes a review of the following components: skin, head, eyes and vision, ear and hearing, mouth, neck, lymph nodes, breasts, peripheral circulation, male genitalia and hernias, female genitalia, rectum, musculoskeletal system, and the neurological system. The psychiatric assessment gathers information on the individual's psychiatric history, description of intellectual functioning, memory functioning, orientation, affect, suicidal or homicidal ideation, current attitude, motor behaviors, judgment, thought processes and medication history.

The OA requires the QIDP to review and make the determination based on the assessments that are performed and the information gathered.

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

- Every three months
- Every six months
- Every twelve months
- Other schedule

Specify the other schedule:

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

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- The qualifications are different.

Specify the qualifications:

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

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

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Evaluation and reevaluation forms are kept by the Independent Service Coordination (ISC) entities under contract with the OA.

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/re-evaluating 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/IID level of care prior to receipt of services.

N: Number of new applicants that complete LOC assessment. **D:** Number of total applicants.

Data Source (Select one):

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

If 'Other' is selected, specify:

OA database of all new participants and date of LOC assessment.

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

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

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

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

Performance Measure:

B3 Number and percent of LOC determinations reviewed that were completed by a qualified evaluator. N: Number of LOC determinations that were completed by a qualified evaluator. D: Number of LOC determinations reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Performance Measure:

B4 Number and percent of Waiver Participants' LOC determinations that used processes and instruments applied appropriately as required by the State.
Numerator: Number of LOC determinations that used processes and instruments applied appropriately as required by the State. 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 checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

As required under the direction of the AA CAP, oversight will be insured by vigilant tracking of performance on the initial LOC evaluation and by the tracking the timeliness of the annual LOC re-evaluations. In addition, there will be extensive monitoring by the contracted Quality Improvement Organization. The QIO team will support the MA with analysis and reporting. Information regarding LOC tracking will be discussed at quarterly OA waiver meetings.

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 individual remediation of findings where claims were submitted prior to initial LOC assessment. Remediation would include, upon discovery, voiding of prior claims.

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

The OA is responsible for individual remediation. A POC is submitted by the provider to the OA for approval within 14 days of notification to provider of findings that cannot be corrected immediately while the reviewers are on site. The provider must correct the findings within 60 calendar days, other than those corrected immediately while the reviewers are on site. In instances of serious findings the provider may be

directed by the OA to correct a finding in a much shorter time frame, including instances of immediate correction, where appropriate. In instances where the provider fails to submit a POC or when the provider fails to submit an acceptable plan, the OA may develop and impose a mandatory POC.

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

ii. Remediation Data Aggregation

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

Responsible Party <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 type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

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

- No
- Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The QIDPs employed by the Operating Agency's contracted entities inform individuals, and/or their legal guardians, about their options during the level of care determination process. The QIDP presents the individual/legal representative with all service options, including both Waiver and ICF/IID services that the individual is eligible to

receive, regardless of availability, in sufficient detail so they are able to make informed choices. If the individual/legal representative does not speak English, has limited proficiency or is non-verbal, the QIDP makes an accommodation. Acceptable accommodations may include use of staff with secondary language skills, translation services, oral assistance and communication devices.

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

The IL 462-1238 form, Choice of Supports and Services, specifically documents the decision to choose Waiver services as an alternative to ICF/IID services at this time. This form also states that choice of supports and services may be changed in the future. The form is signed by the individual/legal representative. The form is available in English and Spanish (IL 462-1238S).

- b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of the IL 462-1238 forms are available in English and Spanish and are maintained by the Independent Service Coordination (ISC) contracted entity.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

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

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

The Operating Agency has a website, www.dd.Illinois.gov, and a toll-free number, 1-888-DDPLANS, specifically designed for families' use in learning more about Illinois' DD service system and in contacting their local entity for assistance with accessing services. Each of these information points is available in both Spanish and English. In addition, brochures and flyers are available in other languages including: Arabic, Bosnian, Chinese, Hindi, Khmer, Korean, Polish, Russian, Urdu and Vietnamese.

Appendix C: Participant Services

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

- a. Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Adult Day Care		
Statutory Service	Community Day Services		
Statutory Service	Residential Habilitation		
Extended State Plan Service	Occupational Therapy (Extended Medicaid State Plan)		
Extended State Plan Service	Physical Therapy (Extended Medicaid State Plan)		
Extended State Plan Service	Speech Therapy (Extended Medicaid State Plan)		
Supports for Participant Direction	Information and Assistance in Support of Participant Direction		
Other Service	24-Hour Stabilization Services		
Other Service	Adaptive Equipment		
Other Service	Behavior Intervention and Treatment		
Other Service	Behavioral Services (Psychotherapy and Counseling)		

Service Type	Service
Other Service	Emergency Home Response Services (EHRS)
Other Service	Home Accessibility Modifications
Other Service	Non-Medical Transportation
Other Service	Personal Support
Other Service	Skilled Nursing
Other Service	Supported Employment - Individual Employment Support
Other Service	Supported Employment – Small Group Supports
Other Service	Temporary Assistance
Other Service	Training and Counseling Services for Unpaid Caregivers
Other Service	Vehicle Modification

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service 

Service:

Adult Day Health 

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1:



Sub-Category 1:

Category 2:



Sub-Category 2:

Category 3:



Sub-Category 3:

Category 4:



Sub-Category 4:

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

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

Service Definition (Scope):

Services generally furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the person centered plan, in a non-institutional, community-based setting, encompassing

both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

Transportation between the participant's place of residence and the Adult Day Care center will be provided as a component of Adult Day Care (ADC) services. The cost of this transportation is included in the rate paid to providers of ADC services.

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

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

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

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

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

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Community-Based Agencies

Provider Qualifications

License (*specify*):

89 Ill. Adm. Code 240

Certificate (*specify*):

Other Standard (*specify*):

59 Ill. Adm. Code 120

Contract with Department on Aging

Verification of Provider Qualifications

Entity Responsible for Verification:

Department on Aging and Waiver Operating Agency

Department on Aging - Surveys are conducted once per contracting period (six years), with

additional surveys conducted as necessary due to complaints or deficiencies.

Waiver Operating Agency (DHS) - Verification of contract with the Department on Aging upon enrollment and annually thereafter.

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service ▼

Service:

Day Habilitation ▼

Alternate Service Title (if any):

Community Day Services

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):

Community Day Services (CDS) assists the with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the

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

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

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

CDS developmental supports includes the reduction of maladaptive behaviors through positive behavioral supports and other methods.

CDS does not include the following:

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

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

CDS includes transportation between the residence and other community locations where Site-Based Developmental Supports occurs. Transportation is provided and billed as an integral part of CDS. The cost of transportation is included in the rate paid to providers of CDS. Training and assistance in transportation is provided as needed.

CDS coordinates and provides supports for valued and active participation in integrated weekday activities that build on the person's interests, preferences, gifts, and strengths while reflecting the person's goals with regard to community involvement and membership.

CDS is designed to promote maximum participation in integrated community life while facilitating meaningful relationships, friendships and social networks with persons without disabilities who share similar interests and goals for community involvement and participation.

CDS shall support and enhance, rather than supplant, an individual's involvement in public education, post-secondary education/training, individualized integrated employment or self-employment, and services designed to lead to these types of employment.

For working-age individuals receiving CDS who are not also working in individualized integrated employment or self-employment, this service includes, and can be exclusively focused on, opportunities for exploration, learning and skill development focused on encouraging pursuit of, and aptitudes for, individualized integrated employment or self-employment.

For individuals receiving CDS that are also working in individualized integrated employment or self-employment, this service includes, and can be exclusively focused on, opportunities for learning and skill development focused on maintaining and expanding aptitudes for continued success in individualized integrated employment or self-employment.

For people who are aging, CDS provides supports for integrated age-appropriate activities.

CDS may provide assistance for active and positive participation in a broad range of integrated community settings that allow the person to engage with people who do not have disabilities who are not paid support

staff. The service is expected to result in the person developing and sustaining a range of valued, age-appropriate social roles and relationships; building natural supports; increasing independence; and experiencing meaningful community integration and inclusion. Activities are expected to increase the individual's opportunity to build connections within his/her local community and include (but are not limited to) the following:

- o Supports to participate in age-appropriate community activities, groups, associations or clubs to develop social networks;
- o Supports to participate in community opportunities related to the development of hobbies or leisure/cultural interests or to promote personal health and wellness (e.g. yoga class, walking group, etc.);
- o Supports to participate in adult education and postsecondary education classes;
- o Supports to participate in formal/informal associations or community/neighborhood groups;
- o Supports to participate in volunteer opportunities;
- o Supports to participate in opportunities focused on training and education for self-determination and self-advocacy;
- o Supports for learning to navigate the local community, including learning to use public transportation and/or private transportation available in the local area;
- o Supports to maintain relationships with members of the broader community (e.g. neighbors, co-workers and other community members who do not have disabilities and who are not paid or unpaid caregivers) through natural opportunities and invitations that may occur.

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

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

- 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
- 2) Payments that are passed through to users of supported employment services.

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

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Community Day Services

Provider Category:

Agency ▼

Provider Type:

Community-Based Agencies

Provider Qualifications**License (specify):**

Certificate (specify):

59 Ill. Adm. Code 119 (Developmental Training)

Other Standard (specify):

59 Ill. Adm. Code 50

59 Ill. Adm. Code 120

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

Waiver Operating Agency (OA)

Frequency of Verification:

Annual certification survey

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Community Day Services****Provider Category:**Agency **Provider Type:**

Special Recreation Associations

Provider Qualifications**License (specify):**

Certificate (specify):

59 Ill. Adm. Code 119 (Developmental Training)

Other Standard (specify):

59 Ill. Adm. Code 50

59 Ill. Adm. Code 120

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

Waiver Operating Agency (DHS)

Frequency of Verification:

Annual certification survey

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:Statutory Service **Service:**Residential Habilitation **Alternate Service Title (if any):****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

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

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

Service Definition (Scope):

Residential Habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include case management, adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs.

Residential Habilitation also includes personal care and protective oversight and supervision. Payment is not made for the cost of room and board. Included in the cost not covered are building maintenance, upkeep and improvement (other than such costs for modification or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code). Residential Habilitation includes the reduction of maladaptive behaviors through positive behavioral supports and other methods. Payment is not made, directly or indirectly, to members of the participant's immediate family. Transportation provided as a component part of Residential Habilitation is included in the rate paid to providers of Residential Habilitation services.

In addition, Residential Habilitation may include necessary nursing assessment, direction and monitoring by a registered professional nurse, and support services and assistance by a registered professional nurse or a licensed practical nurse to ensure the participant's health and welfare. It also includes administration and/or oversight of the administration of medications consistent with the Illinois Nursing and Advanced Practice Nursing Act (225 ILCS 65) and the Mental Health and Developmental Disabilities Administrative Act. Nursing services are considered an integral part of Residential Habilitation services. Meeting the routine nursing needs of participants receiving 24-hour residential services is the responsibility of the residential service provider who must employ or contract with a professional nurse to perform their professional duties including the oversight

and training of direct support staff. Nursing supports are part-time and limited; 24-hour nursing supports, similar to those provided in a nursing facility (NF) or Intermediate Care Facility for individuals with Developmental Disabilities (ICF/IID), are not available to participants in the Waiver. These services are in addition to any Medicaid State Plan nursing services for which the participant may qualify.

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

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

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

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

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

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Residential Habilitation

Provider Category:

Agency 

Provider Type:

Community-Based Agencies (CILA)

Provider Qualifications

License (*specify*):

59 Ill. Adm. Code 115 (Community Integrated Living Arrangements - CILA)

Certificate (*specify*):

Other Standard (*specify*):

59 Ill. Adm. Code 50

59 Ill. Adm. Code 120

59 Ill. Adm. Code 116


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

Verification of Provider Qualifications**Entity Responsible for Verification:**

Waiver Operating Agency (OA)

Frequency of Verification:

Full licensure surveys are conducted at least every three years, with focused surveys conducted more frequently if serious deficiencies are identified.

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Residential Habilitation****Provider Category:**Agency **Provider Type:**

Community-Based agencies (CLF)

Provider Qualifications**License (specify):**

77 Ill. Adm. Code 370 (Community Living Facilities - CLF)

Certificate (specify):**Other Standard (specify):**

59 Ill. Adm. Code 120

59 Ill. Adm. Code 116

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department of Public Health

Frequency of Verification:

Annual surveys and ongoing complaint investigations

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:Extended State Plan Service **Service Title:**

Occupational Therapy (Extended Medicaid State Plan)

HCBS Taxonomy:**Category 1:****Sub-Category 1:**

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

Occupational Therapy services under the waiver differ in nature and scope from Occupational Therapy services in the Medicaid State Plan. Waiver Occupational Therapy focuses on the long-term therapeutic needs of the participant, rather than short-term acute restorative needs. Restorative services are covered under the Medicaid State Plan. This waiver service is only provided to individuals age 21 and over. All medically necessary Occupational Therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

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

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

Services are subject to prior approval by the Operating Agency.

Service Delivery Method (check each that applies):

- 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	Occupational Therapist

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Extended State Plan Service

Service Name: Occupational Therapy (Extended Medicaid State Plan)

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications**License (specify):**

225 ILCS 75/1 et seq.

68 Ill. Adm. Code 1315

Certificate (specify):

Other Standard (specify):

Occupational Therapist may directly supervise a Certified Occupational Therapist Assistant

Verification of Provider Qualifications**Entity Responsible for Verification:**

Waiver Operating Agency and Medicaid Agency

Frequency of Verification:

The Operating Agency (OA) verifies upon enrollment, and the Medicaid Agency (MA) conducts a monthly verification of continuation of licensure.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

Service Title:

Physical Therapy (Extended Medicaid State Plan)

HCBS Taxonomy:**Category 1:**

Sub-Category 1:**Category 2:**

Sub-Category 2:**Category 3:**

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

Sub-Category 4:

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

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

Service Definition (Scope):

Physical Therapy services under the waiver differ in nature and scope from Physical Therapy services in the Medicaid State Plan. Waiver Physical Therapy focuses on the long-term therapeutic needs of the participant, rather than short-term acute restorative needs. Restorative services are covered under the Medicaid State Plan. This waiver service is only provided to individuals age 21 and over. All medically necessary Physical Therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

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

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

Services are subject to prior approval by the Operating Agency.

Service Delivery Method (check each that applies):

- 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	Physical Therapist

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Extended State Plan Service

Service Name: Physical Therapy (Extended Medicaid State Plan)

Provider Category:

Individual ▾

Provider Type:

Physical Therapist

Provider Qualifications**License (specify):**

225 ILCS 90/1 et seq.
68 Ill. Adm. Code 1340

Certificate (specify):

Other Standard (specify):

Physical Therapist may directly supervise a certified Physical Therapy Assistant.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Operating Agency (OA) and Medicaid Agency (MA)

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service ▼

Service Title:

Speech Therapy (Extended Medicaid State Plan)

HCBS Taxonomy:

Category 1:

▼

Sub-Category 1:

Category 2:

▼

Sub-Category 2:

Category 3:

▼

Sub-Category 3:

Category 4:

▼

Sub-Category 4:

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

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

Service Definition (Scope):

Speech Therapy services under the waiver differ in nature and scope from Speech Therapy services in the Medicaid State Plan. Waiver Speech Therapy focuses on the long-term therapeutic needs of the participant, rather than short-term acute restorative needs. Restorative services are covered under the Medicaid State Plan. This waiver service is only provided to individuals age 21 and over. All medically necessary Speech Therapy services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

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

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

Services are subject to prior approval by the Operating Agency.

Service Delivery Method (check each that applies):

- 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	Speech/Language Pathologist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Speech Therapy (Extended Medicaid State Plan)

Provider Category:

Individual ▾

Provider Type:

Speech/Language Pathologist

Provider Qualifications

License (specify):

225 ILCS 110/1 et seq.

68 Ill. Adm. Code 1465

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency (OA) and Medicaid Agency (MA)

Frequency of Verification:

The Operating Agency (OA) verifies upon enrollment and the Medicaid Agency (MA) conducts a monthly verification of continuation of licensure.

Appendix C: Participant Services

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:

Supports for Participant Direction ▾

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction ▾

Alternate Service Title (if any):

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):

Information and Assistance in Support of Participant Direction assists the participant (or the participant’s family or representative, as appropriate) in arranging for, directing and managing services. Practical skills training is offered to enable families and participants to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal support workers, managing workers, and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that participants understand the responsibilities involved with directing their services. The extent of the assistance furnished to the participant or family is specified in the Person Centered Plan.

ISC agencies may not employ persons who may also provide this waiver service or other waiver services to participants.

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

This service is included in the participant’s annual cost maximum, see Appendix C-4. There is no specific service maximum.

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

Provider Category	Provider Type Title
Agency	Community-based agencies

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Information and Assistance in Support of Participant Direction

Provider Category:

Agency ▼

Provider Type:

Community-based agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Entity under contract with the Operating Agency that does not also provide Individual Service and Support Advocacy. Services must be provided personally by a professional defined in federal regulations as a Qualified Intellectual Disabilities Professional.

ISC agencies may not employ persons who may also provide this waiver service or other waiver services to participants.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (DHS)

Frequency of Verification:

Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service ▼

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

Service Title:

24-Hour Stabilization Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

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

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

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

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):

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

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

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

- Welcome of the individual into the new temporary home
- Introduction of the individual to other individuals in the temporary home
- Building rapport/developing relationships with a strong positive philosophy of purpose and goals of the service encouraging safety, security, revised/modified plans of care and understanding of the participant's return to their previous residential setting
- Signs and symptoms of medication toxicity or non-therapeutic medication levels
- Recognizing, describing (verbally and in writing) and addressing escalating behavior
- Tension reduction and behavior de-escalation strategies using non-violent crisis management and intervention techniques that include how to deal with agitation, aggressiveness, crisis de-escalation
- Restraint techniques, if necessary (inclusive of physical, mechanical and chemical restraint) and nonphysical and verbal strategies for the prevention and risk reduction of crisis and other potential incidences of injurious situations
- Organizing meaningful structure of the day, evening and night, again with an emphasis on a strong positive philosophy of purpose and goals of the service directed at implementing a continuation of implemented strategies in the plan of care that follows the individual upon his/her return to the previous setting

- Aiding in return by the individual to the structure of the day, evening or night after escalation of behavior/de-escalation of behavior
- Aiding in return of the individual to his previous home or an appropriate alternative

This enhanced training with a curriculum and trainers approved by the Operating Agency is required in advance of service delivery in the 24-Hour Stabilization Services settings. Refresher training is required by the Operating Agency at least every two years after initial training inclusive of training topics which may be identified through the provider's program operations and provider or Operating Agency quality assurance activities.

The role of QIDPs requires active involvement with direct support staff including intensive data tracking and reporting, behavior modeling, team leadership, and post service progress. The individual QIDP ratio is 1 to 4.

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

Providers must include nursing oversight, mental health expertise, when needed, coordination of ancillary services as part of this service, and ongoing dialogue and planning with other service providers for the participant to ensure a successful return to the former residential setting.

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

The services are temporary and short-term in nature. An individual will typically receive no more than 90 consecutive days of 24-Hour Stabilization Services, but may be approved for additional days by the Operating Agency. The initial goal of the Operating Agency is that these temporary services would last on average no more than 30 consecutive days per participant. 24-Hour Stabilization Services require prior approval by the Operating Agency.

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: 24-Hour Stabilization Services

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License (specify):

CILA which must have a current license under ILCS 59:115.

Certificate (specify):

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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 Person Centered Plan, includes (a) devices, controls, or appliances that enable participants to increase their ability to perform activities of daily living; (b) devices, controls or appliances that enable participants to perceive, control, access or communicate within the environment in which they live; and (c) such other durable equipment not available under the State Plan that is necessary to address participant functional limitations. The cost of the service may include training or technical assistance for the participant.

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

1. The evaluation of the Assistive Technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate Assistive Technology and appropriate services to the participant in the customary environment of the participant.
2. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of Assistive Technology devices for participants.
3. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing Assistive Technology devices.
4. Coordination and use of necessary therapies, interventions, or services with Assistive Technology devices, such as therapies, interventions, or services associated with other services in the person centered plan.
5. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant in the operation and/or maintenance of the AT device.
6. Training or technical assistance for professionals or other persons who provide services to, employ, or are otherwise substantially involved in the major life functions of participants in the operation and/or maintenance of the AT device.

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

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

The cost of the service may include the assessment of the adaptive functioning needs of the participant and the identification of the type of equipment needed by the participant.

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

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

There is a \$15,000 maximum per participant per five-year period for any combination of Adaptive Equipment, Assistive Technology, Home Modifications and Vehicle Modifications. See Appendix C-4.

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

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Equipment Vendors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adaptive Equipment

Provider Category:

Agency 

Provider Type:

Equipment Vendors

Provider Qualifications

License (specify):



Certificate (specify):



Other Standard (specify):

Enrolled vendors approved by the participant or guardian, if one has been appointed.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (OA)

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service 

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

Service Title:

Behavior Intervention and Treatment

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition (Scope):

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

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

A behavior consultant assesses the participant, including analysis of the presenting behavior and its antecedents and consequences, and develops written behavior strategies based upon the participant's individual needs. The strategies are a component of the person centered plan and must be approved by the participant, guardian if one has been appointed, Independent Service Coordination (ISC) agency and the other members of the planning team. The behavior consultant monitors progress on at least a monthly basis and more frequently if needed to address issues with the participant's outcomes. A progress report is prepared by the behavior consultant and sent to the person centered planning team at least every six months. This progress report is available to State staff upon request to evaluate the efficacy of the intervention and treatment.

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

Services are provided by professionals working closely with the participant's direct support staff and unpaid informal caregivers in the participant's home and other natural environments. Direct support staff and unpaid informal caregivers of participants receiving Behavior Intervention and Treatment are vital members of the behavior team. They must be involved in the initial training session to initiate services, and must remain involved with the behavior consultant so that they are able to carry through and reinforce the behaviors being worked on.

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

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

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

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

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

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

- Legally Responsible Person**
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Behavior Consultant

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavior Intervention and Treatment

Provider Category:

Individual ▾

Provider Type:

Behavior Consultant

Provider Qualifications

License (*specify*):

225 ILCS 15/1 et. Seq.

68 Ill. Adm. Code 1400

Certificate (*specify*):

Board Certified Behavior Analyst (at www.bacb.com)

Other Standard (*specify*):

1. Licensed clinical psychologist

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

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

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

7. Professional with a Bachelor's Degree in a human service field and who has completed at least 1,500 hours of training or supervised experience in the application of behaviorally-based therapy models consistent with best practice and research on individuals with Autism Spectrum Disorder.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (AO) and the Medicaid Agency (MA)

Frequency of Verification:

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service 

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

Service Title:

Behavioral Services (Psychotherapy and Counseling)

HCBS Taxonomy:

Category 1:



Sub-Category 1:

Category 2:



Sub-Category 2:

Category 3:



Sub-Category 3:

Category 4:



Sub-Category 4:

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

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

Service Definition (Scope):

Psychotherapy is a treatment approach that focuses on a goal of ameliorating or reducing the symptoms of emotional, cognitive or behavioral disorder and promoting positive emotional, cognitive and behavioral development. Counseling is a treatment approach that uses relationship skills to promote the participant's abilities to deal with daily living issues associated with their cognitive or behavioral problems using a variety of supportive and re-educative techniques.

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

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

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

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

- 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	Licensed Psychotherapists
Individual	Licensed Counselors

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavioral Services (Psychotherapy and Counseling)

Provider Category:

Individual ▾

Provider Type:

Licensed Psychotherapists

Provider Qualifications

License (*specify*):

225 ILCS 15/1 et. Seq.
 68 Ill. Adm. Code 1400
 225 ILCS 20/1 et seq.
 68 Ill. Adm. Code 1470
 225 ILCS 55/1 et seq.
 68 Ill. Adm. Code 1283
 225 ILCS 107/1 et seq.
 68 Ill. Adm. Code 1375

Certificate (*specify*):

Other Standard (*specify*):

Clinical Psychologist
 Clinical Social Worker
 Marriage/Family Therapist
 Clinical Professional Counselor

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency (OA) and Medicaid Agency (MA)

Frequency of Verification:

Operating Agency (OA) verifies upon enrollment.

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Behavioral Services (Psychotherapy and Counseling)

Provider Category:

Individual ▼

Provider Type:

Licensed Counselors

Provider Qualifications

License (specify):

All licensure categories for psychotherapists, plus:

225 ILCS 20/1 et seq.

68 Ill Adm. Code 1470

225 ILCS 107/1 et seq.

68 Ill. Adm. Code 1375

Certificate (specify):

Other Standard (specify):

Social Worker

Professional Counselor

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency (OA) and Medicaid Agency (MA)

Frequency of Verification:

Operating Agency verifies upon enrollment.

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service ▼

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

Service Title:

Emergency Home Response Services (EHRS)

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

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

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

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):

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

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

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

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

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

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified vendor

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Emergency Home Response Services (EHRS)**

Provider Category:Agency **Provider Type:**

Certified vendor

Provider Qualifications**License (specify):****Certificate (specify):**

Certified by the Department on Aging

Other Standard (specify):

Annual written rate agreements with the Department on Aging and the OA.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Department on Aging

Operating Agency (OA)

Frequency of Verification:

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

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

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:Other Service 

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

Service Title:

Home Accessibility Modifications

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

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

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

Service Definition (Scope):

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's support plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the adaptive equipment that are necessary for the welfare of the participant.

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

Excluded are those adaptations or improvements to the home that are of general utility, such as carpeting, roof repair, central air conditioning, and are not of direct remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit. Seasonal items such as swimming pools and related equipment are excluded. All services shall be provided in accordance with applicable State or local building codes.

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

There is a \$15,000 maximum per participant per five-year period for any combination of Adaptive Equipment/Assistive Technology, Home and Vehicle Modifications.

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

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

Service Delivery Method (check each that applies):

- 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	Construction Companies
Individual	Independent Contractor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Accessibility Modifications

Provider Category:

Agency ▼

Provider Type:

Construction Companies

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Enrolled vendor approved by the participant or guardian, if one has been appointed.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Waiver Operating Agency (OA)

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Home Accessibility Modifications****Provider Category:**Individual **Provider Type:**

Independent Contractor

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Enrolled vendor approved by the participant or guardian, if one has been appointed.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Waiver Operating Agency (OA)

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:Other Service

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

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition (Scope):

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

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

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

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

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

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

Service Delivery Method (check each that applies):

- 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	Individual Carriers
Agency	Community-based agencies
Agency	Public and private carriers
Agency	Special Recreation Associations

Appendix C: Participant Services

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

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

Provider Category:

Individual ▾

Provider Type:

Individual Carriers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Drivers must have appropriate state licenses and proof of insurance

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (OA)

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

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

Provider Category:

Agency ▾

Provider Type:

Community-based agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Drivers must have appropriate state licenses and proof of insurance

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (OA)

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Non-Medical Transportation****Provider Category:**Agency **Provider Type:**

Public and private carriers

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Must meet existing requirements for public and private carriers

Verification of Provider Qualifications**Entity Responsible for Verification:**

Waiver Operating Agency (OA)

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Non-Medical Transportation****Provider Category:**Agency **Provider Type:**

Special Recreation Associations

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Drivers must have appropriate state licenses and proof of insurance

Verification of Provider Qualifications**Entity Responsible for Verification:**

Waiver Operating Agency (OA)

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service 

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

Service Title:

Personal Support

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17090 other 

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):

Personal Support services include:

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

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

over other support services. Such assistance also may include the supervision of participants as provided in the support plan.

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

Personal Support is not intended to include professional services, home cleaning services, or other community services used by the general public.

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

The need for Personal Support and the scope of the needed services must be documented in the person centered plan.

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

Personal Support will not be duplicative of other services in the Waiver, i.e., Residential Habilitation, Developmental Training, etc., since the scope of Personal Support services are already included in those services.

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

For participants still enrolled in secondary education, no Personal Support services may be delivered during the typical school day relative to the age of the participant or during times when educational services are being provided.

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

- 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	Personal Support Worker
Agency	Community-Based Agencies and Special Recreation Associations

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Support

Provider Category:

Individual ▼

Provider Type:

Personal Support Worker

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Aged 18 or older, and is deemed by the participant or guardian, if one has been appointed, to be qualified and competent to meet the participant's needs and carry out responsibilities assigned via the person centered plan.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Service (FMS) entities and Waiver Operating Agency (OA).

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Personal Support

Provider Category:

Agency

Provider Type:

Community-Based Agencies and Special Recreation Associations

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

The provider must have a contract with the Operating Agency (OA). Per contractual requirements, employees must complete Operating Agency-approved direct support personnel training program and pass competency-based training assessments (40 hours of classroom and 80 hours of on-the-job training) and be certified as direct support personnel (DSP).

All employees of the provider must pass required background checks including criminal background and Health Care Worker Registry checks prior to employment and annually thereafter.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (OA)

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service 

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

Service Title:

Skilled Nursing

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):

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

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

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

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

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

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**

Provider managed

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

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Registered Nurse; or Licensed Practical Nurse, under supervision by an RN

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Skilled Nursing

Provider Category:

Individual ▾

Provider Type:

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

Provider Qualifications

License (specify):

225 ILCS 65/1 et seq.

68 Ill. Adm. Code 1300

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency (DHS) and Medicaid Agency (MA)

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service ▾

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

Service Title:

Supported Employment - Individual Employment Support

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):

Supported Employment-Individual Employment Support services are the ongoing supports to participants who, because of their disabilities, need on-going supports to obtain and maintain an individualized integrated employment or self-employment defined as follows:

Individualized Integrated Employment: Sustained paid employment in an individualized, competitive or customized job, in an integrated work setting in the general workforce, for which an individual is compensated at or above the state's minimum wage (or local minimum wage if higher), with the optimal goal being not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. An integrated work setting means a setting typically found in the community in which individuals interact with non-disabled individuals, other than non-disabled individuals who are providing services to those individuals, to the same extent that non-disabled individuals in comparable positions interact with other persons.

Individualized Integrated Self-Employment: Sustained paid self-employment that is home-based or conducted in an integrated setting(s) where pre-tax income, after business expenses are deducted, divided by the individual's hours worked is equivalent to no less than the state's minimum wage (or local minimum wage if higher), after a reasonable self-employment start-up period. An integrated setting means a setting where individuals without disabilities engaged in the same or a similar type of self-employment typically work, in which individuals interact with non-disabled individuals, other than non-disabled individuals who are providing services to those individuals, to the same extent that non-disabled individuals in comparable types of self-employment interact with other persons.

These services are designed to support the achievement of individualized integrated employment or self-employment outcomes consistent with the individual's employment and career goals.

Supported Employment—Individual Employment Support services are individualized and may include one or more of the following components:

- Job and Career Exploration;
- Discovery/Career Planning;
- Job Development/Customized Job Placement or Self-Employment Start-Up;
- Supports to maintain individualized integrated employment or self-employment including job analysis, on-the-job training and systematic instruction, job coaching including as-needed employer consultation/support,

mobility training and support, and other workplace assistance services including services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting; and

- Benefits counselling, planning, analysis and financial literacy.

Each of these five components are further defined in State guidelines.

Supported employment individual employment supports may also include support to establish or maintain self-employment, including home-based self-employment. Services for self-employment may include: (a) aiding the participant to identify potential business opportunities (as part of Discovery); (b) assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business (as product of Career Planning); (c) identification of the supports that are necessary in order for the participant to operate the business (as part of Self-Employment Start-Up); and (d) ongoing assistance, counseling and guidance once the business has been launched (as part of Supports to Maintain Integrated Self-Employment). Waiver funds may not be used to defray expenses associated with starting up or operating a self-employment business.

When services are funded to enable a participant to obtain individualized integrated employment, the expected outcome that the individual makes an informed choice as to his or her employer of record.

In situations where the provider of Supported Employment -Individual Employment Support services wishes to hire a participant, to work for an organization or entity the provider owns or operates, in a job that meets the definition of individualized integrated employment, the provider shall maintain a policy, and inform individuals receiving the service of the policy, that gives a participant the option to identify a separate provider of Supported Employment-Individual Employment Support services that can provide the on-going supports the person needs to maintain the job, if a situation arises where the participant wishes to change provider for any reason. This will preserve the Medicaid free-choice-of-provider requirement while not discouraging providers from hiring waiver participants in individualized integrated employment situations.

Supported Employment – Individual Employment Support services include transportation. Transportation of the individual to and from these services is included in the rates paid for these services, if needed by individuals participating in these services; however, face-to-face time spent transporting an individual to and from these services is not considered billable time. Transportation during the provision of these services is also included in the rates paid for these services.

A provider of Supported Employment-Individual Employment Support services may also receive Social Security's Ticket to Work Outcome and Milestone payments. These payments do not conflict with CMS regulatory requirements and do not constitute an overpayment of Federal dollars for services provided.

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

Supported Employment—Individual Employment Support does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business.

Supported Employment—Individual Employment Support does not include supports for volunteering, but may be used to support participation in vocationally-focused internships. Internships are distinguished from volunteering in that:

- Volunteering never occurs in for-profit businesses or organizations that do not have charitable status;
- Internships are focused on developing specific work skills while volunteering is focused on developing general non-job-specific skills for employment and/or charitable contribution;
- Internships should lead to individualized integrated employment or self-employment after a reasonable period of time, while volunteering may continue indefinitely if the goal is charitable contribution.

If internships are unpaid, all federal labor laws must be followed. Internships that are paid must be paid at minimum wage or higher; however, waiver funding cannot be used to pay wages to participants for internships or employment.

The Supported Employment—Individual Employment Support provider shall be responsible for any personal assistance needs during the time that Supported Employment-Individual Employment Support services are provided; however, personal assistance services may not comprise the entirety of the Supported Employment—Individual Employment Support service(s) being provided to an individual.

This waiver will not cover Supported Employment-Individual Employment Support services which are otherwise available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). Documentation is maintained that the specific type(s) of Supported Employment-Individual Employment Support services being provided is not immediately available, or available without undue delay, to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

This service may be combined with services being provided to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.), so long as this service is not duplicative of what is being provided to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.).

An individual's person-centered support plan may include more than one non-residential habilitation service (Supported Employment-Individual, Supported Employment-Small Group, Community Day Services); however, they may not be billed for during the same period of time (e.g., the same 15 minute or hour unit of time).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- o Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
- o Payments that are passed through to users of supported employment services; or
- o Payments for training that is not directly related to an individual's supported employment program.

These services do not include supporting paid employment or training in a sheltered workshop or similar facility-based setting.

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supported Employment - Individual Employment Support

Provider Category:

Agency ▼

Provider Type:

Community-Based Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

• Job Coach Qualifications:

o High School Diploma or GED

o Pass registry and background check(s) required by the OA

o Complete all staff training requirements as specified in OA guidelines

o Successfully complete Job Coach certification within 6 months of hire

o Successfully complete "TRN Job Coaching and Consulting on-demand" on-line competency-based training: <http://trn-store.com/catalog/job-coaching-and-consulting>

o Complete 40 hours of job shadowing with Supported Employment – Individual Employment Supports in at least three different employment situations

o Valid driver's license if providing service in area where this is necessary.

o Automobile liability insurance if DSP will be transporting waiver participants in his/her own vehicle.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Waiver Operating Agency (OA)

Frequency of Verification:

The OA verifies upon enrollment and conducts an annual review of contract continuation.

Appendix C: Participant Services**C-1/C-3: Service Specification**

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

Service Type:

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:

Supported Employment – Small Group Supports

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):

This service provides employment services and training activities to support successful transition to individualized integrated employment or self-employment, or to supplement such employment and/or self-employment when it is only part-time. The maximum size of a small group is six (6) persons in order to maximize the likelihood of interaction between Supported Employment-Small Group participants and non-disabled persons also present in the setting and reduce stigma associated with congregation of individuals with disabilities.

Services typically include employment in integrated business, industry and community settings. Examples include mobile crews and small enclaves participating in integrated community employment that results in acquisition of knowledge, skills and experiences that facilitate transition to individualized integrated employment or self-employment, or that supplement such employment or self-employment when it is only part-time.

- In the enclave model, a small group of people with disabilities (no more than 6 persons with disabilities and ideally also including workers without disabilities) is trained and supervised to work among employees who are not disabled at the host company's work site. Persons in the enclave may work as a team at a single work area or may work in multiple areas throughout the company. The Supported Employment—Small Group provider is responsible for training, supervision, and support of participants. The provider is expected to conduct this service in integrated business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others in the setting who do not have disabilities. The experience should allow opportunities for routine interactions with others without disabilities in the setting and involvement from supervisors and co-workers without disabilities (not paid to deliver this service) in the supervision and support of individuals receiving this service.
- In the mobile work crew model, a small crew of workers (including no more than 6 persons with disabilities and ideally also including workers without disabilities) work as a distinct unit and operate as a self-contained business that generates employment for their crew members by selling a service. The crew typically works at several locations within the community. The Supported Employment—Small Group provider is responsible for training, supervision, and support of participants. The provider is expected to conduct this service in integrated business, industry or community settings that meet all HCBS setting standards and do not isolate participants from others who do not have disabilities. The experience should allow opportunities for routine interactions with people without disabilities (including fellow crew members, customers, etc.) in the course of performing services.

For individuals not already working in individualized integrated employment or self-employment, this service involves small group career planning and exploration, small group Discovery classes/activities, and other educational opportunities related to working successfully in individualized integrated employment or self-employment (e.g. financial literacy; basic work incentives overview). Such activities must be conducted in appropriate non-disability-specific settings (e.g. Job Centers, businesses, post-secondary education campuses, libraries, etc.) All settings must meet all HCBS setting standards and must not isolate participants from others who do not have disabilities.

Supported Employment—Small Group services shall be provided in a way that presumes all participants are capable of working in individualized integrated employment and/or self-employment. Participants in this service who are not yet working in individualized integrated employment or self-employment shall be encouraged, on an ongoing basis, to explore and develop their interests, strengths, and abilities relating to individualized integrated employment and/or self-employment. In order to reauthorize this service, the Person Centered Plan (PCP) must document that such opportunities are being provided through this service, to the individual, on an on-going basis. The PCP shall also document and address any barriers to the individual transitioning to individualized integrated employment or self-employment if the person is not already participating in

individualized integrated employment or self-employment.

Any individual using this service to supplement part-time individualized integrated employment or self-employment shall be offered assistance to increase hours in individualized integrated employment and/or self-employment as an alternative to continuing this service.

The expected outcome of this service is the acquisition of knowledge, skills and experiences that facilitate career development and transition to individualized integrated employment or self-employment, or that supplement such employment and/or self-employment when it is only part-time. The individualized integrated employment or self-employment shall be consistent with the individual's personal and career goals.

Paid work under Supported Employment—Small Group shall be compensated at minimum wage or higher. Supported Employment – Small Group Support arrangements established prior to July 1, 2017, may pay participants at subminimum wage as long as the employer is certified for subminimum wage by the Department of Labor. Arrangements established on or after July 1, 2017 must pay individuals at or above minimum wage.

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

Supported Employment—Small Group does not include prevocational services, including employment or training provided in facility based or sheltered work settings, nor does it include supports for volunteering. Supported Employment—Small Group services cannot be provided in settings that are not regular business, industry and community settings that also meet the HCBS settings rule standards.

Transportation of the individual to and from these services is included in the rates paid for these services, if needed by individuals participating in these services; however, face-to-face time spent transporting an individual to and from these services is not considered billable time. Transportation during the provision of these services is also included in the rates paid for these services.

The Supported Employment—Small Group provider shall be responsible for any personal assistance needs during the hours that Supported Employment-Small Group services are provided; however, the personal assistance services may not comprise the entirety of the Supported Employment—Small Group service.

This waiver will not cover Supported Employment-Small Group services which are otherwise timely available to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.). Documentation is maintained that the specific type(s) of Supported Employment-Small Group services being provided is not immediately available, or available without undue delay, to the individual under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.).

This service may be combined with services being provided to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.), so long as this service is not duplicative of what is being provided to the individual under section 110 of the Rehabilitation Act of 1973, or the IDEA (20 U.S.C. 1401 et seq.).

An individual's person-centered support plan may include more than one non-residential habilitation service (Supported Employment-Individual, Supported Employment-Small Group, Community Day Services); however, they may not be billed for during the same period of time (e.g., the same 15 minute or hour unit of time).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- o Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;
- o Payments that are passed through to users of supported employment services; or
- o Payments for training that is not directly related to an individual's supported employment program.

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supported Employment – Small Group Supports

Provider Category:

Agency

Provider Type:

Community-Based Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

• Job Coach Qualifications:

o High School Diploma or GED

o Pass registry and background check(s) required by the OA

o Complete all staff training requirements as specified in OA guidelines

o Successfully complete Job Coach certification within 6 months of hire

o Successfully complete TRN "Job Coaching and Consulting on-demand" on-line competency-based training: <http://trn-store.com/catalog/job-coaching-and-consulting>

o Complete 40 hours of job shadowing with Supported Employment – Individual Employment Supports in at least three different employment situations

o Valid driver's license if providing service in area where this is necessary.

o Automobile liability insurance if DSP will be transporting waiver participants in his/her own vehicle.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (OA)

Frequency of Verification:

The OA verifies upon enrollment and conducts an annual review of contract continuation.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service 

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

Service Title:

Temporary Assistance

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):

Temporary Assistance services are provided on an emergency temporary basis because of the absence or incapacity of the persons who normally provide unpaid care. Absence or incapacity of the primary caregiver(s) must be due to a temporary cause, such as hospitalization, illness, injury, or other emergency situation.

Temporary Assistance services are not available for caregiver absences for vacations, educational or employment-related reasons, or other non-emergency reasons.

Temporary Assistance services include:

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

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

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

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

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

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

The need for Temporary Assistance and the scope of the needed services must be documented in the person centered plan.

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

The rate, amount and frequency for this service must be specified in the Service Agreement(s) and in the Person Centered Plan (PCP).

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

Temporary Assistance services up to an additional \$4000 per episode may be authorized for family emergencies subject to prior approval by the Operating Agency. Temporary Assistance services may not exceed \$2,000 in any single month and may not be authorized for more than two consecutive months or 60 consecutive days. The limits were established through input from an external advisory committee of consumers, family members, providers, and other advocates and are based on their opinions of individuals' and families' needs.

This service is subject to prior approval by the Operating Agency. The Independent Service Coordination (ISC) agency will submit a written request for prior authorization for Temporary Assistance services on behalf of the individual. The OA will respond in writing to the request within 30 calendar days. However, when an unplanned need occurs, Temporary Assistance services may begin upon receipt of verbal approval from the OA. The OA will provide verbal approval ASAP but no later than 24 hours of receipt of request, in those cases of unplanned need. Subsequent written approval is issued to the participant and ISSA by the OA.

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

Service Delivery Method (check each that applies):

- 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	Temporary Assistance/Personal Support Worker
Agency	Community-Based Agencies and Special Recreation Associations

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Temporary Assistance

Provider Category:

Individual ▾

Provider Type:

Temporary Assistance/Personal Support Worker

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Aged 18 or older and is deemed by the participant or guardian, if one has been appointed, to be qualified and competent to meet the participant's needs and carry out responsibilities assigned via the person centered plan.

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

Verification of Provider Qualifications**Entity Responsible for Verification:**

Financial Management Service (FMS) entities and Waiver Operating Agency (OA)

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Temporary Assistance**

Provider Category:

Agency ▾

Provider Type:

Community-Based Agencies and Special Recreation Associations

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

The provider must be under contract with the Operating Agency. Per these contracts, employees must complete DHS-approved direct support personnel training program and pass competency-based training assessments (40 hours of classroom and 80 hours of on-the-job training) and be certified as direct support personnel (DSP).

All employees must pass required background checks including criminal background and Health Care Worker Registry checks prior to employment and annually thereafter.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Waiver Operating Agency (OA)

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: 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:

Training and Counseling Services for Unpaid Caregivers

HCBS Taxonomy:**Category 1:**

Sub-Category 1:**Category 2:**

Sub-Category 2:**Category 3:**

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

Sub-Category 4:

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

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

Service Definition (Scope):

Training and Counseling services are provided to individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a Waiver participant. Training includes instruction about treatment regimens and other services included in the support plan, use of equipment specified in the person centered plan, and includes updates as necessary to safely maintain the participant at home. All training for individuals who provide unpaid support to the participant must be included in the participants Person Centered Plan.

Training furnished to individuals who provide uncompensated care and support to the participant must be directly related to their role in supporting the participant in areas specified in the person centered plan.

Counseling must be aimed at assisting the unpaid caregiver in understanding and meeting the needs of the participant.

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

This service will not be duplicative of other services in the Waiver. For example, the Adaptive Equipment/Assistive Technology service includes training for family members in the use and/or maintenance of the device, therefore, Training and Counseling could not cover this type of training.

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

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

Service Delivery Method (check each that applies):

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

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

- Legally Responsible Person**
 Relative
 Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Training and Counseling Services for Unpaid Caregivers

Provider Category:

Agency ▼

Provider Type:

Specialized Training providers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Training programs, workshops or events deemed qualified by the participant/guardian (if one has been appointed) and approved by the ISC. Examples include CPR instruction, first aid, and programs on disability-specific topics such as epilepsy, autism, etc.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (OA)

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Training and Counseling Services for Unpaid Caregivers

Provider Category:

Individual ▾

Provider Type:

Licensed counselors

Provider Qualifications

License (specify):

225 ILCS 15/1 et. seq.
 68 Ill. Adm. Code 1400
 225 ILCS 20/1 et seq.
 68 Ill. Adm. Code 1470
 225 ILCS 55/1 et seq.
 68 Ill. Adm. Code 1283
 225 ILCS 107/1 et seq.
 68 Ill. Adm. Code 1375
 225 ILCS 20/1 et seq.
 68 Ill Adm. Code 1470
 225 ILCS 107/1 et seq.
 68 Ill. Adm. Code 1375

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (OA)

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service ▾

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

Service Title:

Vehicle Modification

HCBS Taxonomy:

Category 1:

Sub-Category 1:

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

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

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

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

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

Service Definition (Scope):

Vehicle Modifications are adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the person centered plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The vehicle that is adapted must be owned by the participant, a family member with whom the participant lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the participant and is not a paid provider of such services.

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

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

This service will not be duplicative of other services in the waiver. For example, vehicle modifications are within the transportation component of Residential Habilitation and Developmental Training services.

The following are specifically excluded:

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

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

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Equipment Vendor and Installer

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modification

Provider Category:

Agency ▼

Provider Type:

Equipment Vendor and Installer

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Enrolled vendor approved by the participant or guardian, if one has been appointed.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency (OA)

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

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

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

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:

Case Management services are provided by Qualified Intellectual Disability Professional (QIDP) staff working for Independent Service Coordination (ISC) agencies under contract with the Operating Agency.

Appendix C: Participant Services

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

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

- No. Criminal history and/or background investigations are not required.**
- Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Criminal background checks with the Illinois State Police are required for staff hired by agencies providing Residential Habilitation services, Site-Based Developmental Supports, Adult Day Care, Supported Employment, Information and Assistance in Support of Participant Direction, Personal Support, or Individual Service and Support Advocacy. These agencies may not knowingly hire or retain any person in a full-time, part-time or contractual direct service position if that person has been convicted of committing or attempting to commit one or more of the offenses in the Illinois Health Care Worker Background Check Act (225 ILCS 64/25), unless the person obtains a waiver of the conviction.

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

When determining whether to grant a waiver for employees or potential employees found on the CANTS registry, the OA reviews applications for a waiver based on individual circumstances. The factors considered include, but are not limited to, the following:

- Circumstances surrounding the event,
- Work history of the employee requesting the waiver,
- Recommendation of employer or potential employer,
- The provider's quality review and licensure survey results,
- The amount of supervision the employee will receive,
- The length of time since the incident,
- The age of the employee at the time of the incident, and
- The results of a cross check in the Adult Registry.

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

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

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

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

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

- **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

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

By statute, the Illinois Department of Public Health maintains an adult abuse and neglect registry. The registry is called the Healthcare Worker Registry (formerly known as the Nurse Aide Registry). The state law governing the Health Care Worker's Registry is the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30).

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

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

Abuse/Neglect screenings are required for all individuals providing Residential Habilitation, Developmental Training, Supported Employment, Information and Assistance in Support of Participant Direction, Personal Support or Independent Service Coordination (ISC) services. Such individuals may not be employed in any capacity until the employer has checked the individual against:

- The Illinois Department of Public Health (IDPH) Health Care Worker Registry, and
- The Illinois Department of Children and Family Services (DCFS) State Central Register (Children's Abuse and Neglect Tracking System - CANTS).

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

When determining whether to grant a waiver for employees or potential employees found on the CANTS registry, the OA reviews applications for a waiver based on individual circumstances. The factors considered include, but are not limited to, the following:

- Circumstances surrounding the event,
- Work history of the employee requesting the waiver,
- Recommendation of employer or potential employer,
- The provider's quality review and licensure survey results,
- The length of time since the incident,
- The age of the employee at the time of the incident, and
- The results of a cross check in the Adult Registry.

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

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

Appendix C: Participant Services

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

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

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

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

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

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- Self-directed**
- Agency-operated**

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.**

Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

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

Parents, other relatives, and legal guardians may provide Personal Support, Temporary Assistance, and Non-medical Transportation services. The relative or legal guardian must meet the same provider qualification criteria, and pass the required background checks, that are applicable to any provider rendering the same services.

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

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

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

The Case Manager, also known as the ISC, plays a key role in monitoring the implementation of the person centered plan and reporting any non-compliant issues or problems to the OA if direct interventions by the ISC do not work.

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

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

Other policy.

Specify:

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

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

Information 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.

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

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

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

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

C1 Number and percent of licensed or certified providers who meet initial licensure/certification standards prior to furnishing waiver services. N: Number of newly enrolled licensed or certified providers who meet initial standards. D: Total number of newly enrolled licensed or certified providers.

Data Source (Select one):

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

If 'Other' is selected, specify:

OA provider licensure and certification database

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

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

Performance Measure:

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

Data Source (Select one):

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

If 'Other' is selected, specify:

MA reviews all licensed clinicians. OA and MA merge and compare data for analysis and reporting purposes.

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

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

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 The number and percent of non-licensed/non-certified providers reviewed, by provider type, who meet initial waiver provider qualifications. N: Number of non-licensed/non-certified providers who met initial qualifications. D: Total number of newly enrolled non-licensed/non-certified providers.

Data Source (Select one):

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

If 'Other' is selected, specify:

OA database on provider qualifications

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

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

Performance Measure:

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

Data Source (Select one):

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

If 'Other' is selected, specify:

OA database on provider qualifications

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

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

Performance Measure:

C6 Number and percent of independent personal support providers (domestic employees) screened by FMS vendors (on behalf of waiver participants who self-direct and exercise employer authority) who passed initial background and registry checks and thus were deemed eligible for hire. N: Number of domestic employees who passed initial checks. D: Total number of domestic employees hired.

Data Source (Select one):

Other

If 'Other' is selected, specify:

FMS vendor reports

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

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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. N: Number of providers who met training requirements. D: Total number of providers subject to training requirements.

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

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

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

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.

As required under the direction of the AA CAP, oversight will include the MA working with the contracted QIO to monitor the service planning process and compliance and ensure that performance measures are being followed and met. In addition, the MA will work with the OA to ensure that the service plans comply with Person Centered Planning. Other measures, if needed, will be addressed via the AA CAP and discussed monthly with CMS.

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 individual remediation which upon discovery includes: imposing sanctions, as appropriate, terminating provider agreements, and prohibition of new placements/enrollments.

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

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

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

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

ii. Remediation Data Aggregation

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

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

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

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

The service limits are discussed verbally during the annual person centered planning process. The ISC reviews service limits with the participant and guardian, if applicable. The written person centered plan is signed by the participant, or his or her guardian (if one has been appointed), and the ISC. Providers responsible for the plan's implementation must also sign the plan.

Maximum for Modifications and Tangible Items

There is a \$15,000 maximum per participant per five-year period for any combination of Adaptive

Equipment/Assistive Technology, and Home and Vehicle Modifications. Within the five-year maximum, there is also a \$5,000 maximum per address for permanent home modifications for rented homes. Participants are informed of their right to request a fair hearing, in the event any requests are denied. Participants are notified of the limits in the OA's Waiver manual.

Any combination of Community Day Services and Supported Employment services cannot exceed 1100 hours per year. This limit was established through a review of historical expenditures and is based on hours of operation for day programs established in Illinois Administrative Code, Title 59, Chapter 1, Part 119.

Behavior Intervention and Treatment services cannot exceed 104 hours per year. These limits were established through a review of historical expenditures.

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

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

The annual home-based supports budget limits are based on the Illinois Home-Based Support Services Law for Mentally Disabled Adults [405 ILCS 80]. The limits are based on Social Security benefit levels and are adjusted each January when Social Security benefits are adjusted for cost of living increases. These statutory budget limits were set through a public legislative process that included opportunities for public comment by advocates and individuals with mental disabilities and their families.

The total amount of Waiver services provided in any month is determined by the person centered plan of the participant within the program maximums. The annual person centered plan is developed by the ISC and is based on assessments of the participant's needs.

Written notices of changes to limits are sent to all participants/guardians (as applicable), Financial Management Service (FMS) entities, and Independent Service Coordination (ISC) agencies by the OA.

The monthly home-based support services budget limits, currently \$2,205 for calendar year 2017 (or \$1,470 if between the ages of 18 and 22 and still attending school), together with natural supports, general community resources, school-based services (for young adult participants still attending school), and Medicaid State Plan services are sufficient to meet the participant's needs. If the health and welfare of the participant cannot be assured on a long-term basis within the cost limit of home-based supports in combination with other natural supports and community resources, the participant will be considered for other service options within the Waiver, including residential service supports that are not participant-directed and some that are provided 24 hours a day, seven days a week. Participants are notified of the opportunity to request a fairing hearing if enrollment is denied.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

Note instructions at Module 1, Attachment #2, 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.

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

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

These group home settings were included as part of the recent survey conducted by an outside contractor (Univ. of Illinois at Springfield) to determine compliance with the new HCB setting requirements. The survey results are part of the Waiver Transition Plan submitted to CMS. Additional activities planned to verify the survey results and full compliance are outlined in the Waiver Transition Plan.

Also, key to our Statewide Transition are planned site visits to further address compliance that may be issues in Illinois statutes, rules, Medicaid authority and Operating entities policies, contracts, procedures, forms and the setting's internal policies and practices, all to ensure the highest level of compliance with rules relating to settings. The Illinois Transition Plan has timeline for all of these deliverables.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

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 Independent Service Coordination (ISC) agency. The ISC's are Qualified Intellectual Disabilities Professionals. Per contractual agreement with the OA, the ISCs are prohibited from providing direct service to waiver participants.

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

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 ISC. 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 ISC 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 ISC 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 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

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 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 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 person centered plan meetings are convenient to the Waiver participant and guardian.

To begin the person center planning process, ISC's 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 ISC explains to the participant the types of services available under the Waiver, as well as all willing and qualified providers of services. The ISC 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 ISC is responsible for implementing the plan and monitoring its on-going implementation and effectiveness. The ISC 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 ISC 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 ISC 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.

As part of the planning process with the participant and guardian (if one has been appointed), the ISC is required to assess the potential risks to the health, welfare and safety of the participant. Guidelines on the minimum

components of the risk assessment are contained in the Waiver Manual. The Waiver Manual is posted on the OA website and copies are available upon request.

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

Strategies to mitigate risk must be incorporated into the person centered plan, including the consequences of choices that may involve risk, documenting the issues concerned and the decisions made. The team will describe, when it is necessary to do so, to the participant and the participant's support network, how the preferences might be limited because of imminent significant danger to the participant's health, safety, or welfare based on the following:

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

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

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

On an ongoing basis and at least annually, the ISC, assists participants if they want to change providers. At any time, a participant may ask about other providers offering the types of services they are receiving in their geographic area. The person centered plan is updated when new providers are selected.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

ISC, 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 ISC is responsible for monitoring person centered plan implementation and participant health and welfare. The minimum frequency of contact for monitoring the plan's implementation, including direct, in-person contact with the participant, is annually. This annual monitoring visit is in addition to the direct contact for plan development. The ISC reviews that services delivered are in accordance with the person centered plan and that all services called for in the person centered plan are being delivered.

If the ISC determines the plan is not meeting the individual's assessed needs, the ISC 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 person centered plan issues, the ISC 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.

Upon enrollment and at least annually thereafter, during the planning process, the ISC explains to the participant what services are available under the Waiver. The ISC is responsible for informing participants that a listing of all qualified providers by type of provider is available on the OAs website. Upon request, a written copy of the listing will be provided 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>.

Back-up plans are developed as part of the plan development process. Back-up plans are effective when the absence of the service presents a risk to the health, welfare and/or safety of the participant.

The ISC is responsible for implementing the plan and monitoring its on-going implementation and effectiveness. The ISC 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 ISC 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 ISC must then monitor that the services are delivered as specified in the plan.

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

- b. Monitoring Safeguards.** *Select one:*

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

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

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. N: Number of respondents who reported they received services to address their needs. D: Total respondents sampled.

Data Source (Select one):

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

If 'Other' is selected, specify:

Responsible Party for data collection/generation <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 Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <div style="border: 1px solid gray; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid gray; height: 20px; width: 100%;"></div>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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. N: Number of PCPs with strategies to address all identified health and safety risks. D: Total PCPs sampled with an assessed health and/or safety risk.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Performance Measure:

D3 Number and percent of person centered plans reviewed that address all participant needs identified by the assessments. N: PCPs that addressed all participant needs. D: All sample PCPs 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 Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

D4 Number and percent of participants' OA PCPs that address all personal goals by the assessment. N: Number of OA PCPs reviewed that addressed all personal goals identified by the assessment. D: Total number of OA PCPs 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 Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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 PCP's reviewed that were developed in accordance with state requirements. N: Number of PCP's that were developed in accordance with state requirements. D: Total number of PCP'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"/> 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"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:
D6 Number and percent of PCP's where the PCP was approved by all entities within the required timeframe. N: Number of PCP's whose contents were developed in accordance with state requirements. D: Total number of PCP's 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 Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input type="text"/>
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Data Aggregation and Analysis:

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

Performance Measure:

D7 Number and percent of PCP's where the PCP meeting occurred within 365 days of the previous PCP. N: Number of PCP's where the PCP meeting occurred within 365 days of the previous PCP. D: Total number of PCP's 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 Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
		<input type="checkbox"/> Other

	<input checked="" type="checkbox"/> Continuously and Ongoing	Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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 Person Centered Plan updated at least annually or within 30 days of the identified change in the participants needs. N: Number of participants who have had their PCP's updated annually or within 30 days of the identified change in a participants needs. D: Number of waiver 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 type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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 a minimum of one visit from the ISC entity under contract with the OA to monitor that services are being delivered in accordance with the services in the plan of care. N: Number of participants who received an ISC visit. D: Number of participants in the representative 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 Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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 PCP. **N:** Number of participants who received services as specified in their PCP. **D:** Number of participants reviewed in sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	Specify:	
	<input style="width: 100%;" 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 Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

D11 Number and percent of satisfaction survey respondents sampled who reported the receipt of all services listed in the person centered plan. N: Number of respondents who reported receipt of all services in their PCP. D: Total number of survey respondents.

Data Source (Select one):

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

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<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"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>

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

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. N: Number of participant records reviewed that document participants were informed at least annually of the right to choose their providers. D: Total number of records reviewed based on a representative 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 Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input 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 type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually

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"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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.

As required under the direction of the AA CAP, oversight will be insured by extensive review of participant service plans. There will be extensive monitoring by the contracted Quality Improvement Organization. The QIO team will support the MA with analysis and reporting. The MA will work with the OA to ensure that waiver program service plans comply with the Person Centered Planning process. As per the direction of the AA CAP, this review activity will be updated monthly and provided to CMS.

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 individual remediation. A POC is submitted by the provider to the OA for approval within 14 days of notification to provider of findings that cannot be corrected immediately while the reviewers are on site. The POC must correct the findings within 60 calendar days, other than those corrected immediately while the reviewers are on site. In instances of serious findings the provider may be directed by the OA to correct a finding in a much shorter time frame, including instances of immediate correction, where appropriate. In instances where the provider fails to submit a POC or when the provider fails to submit an acceptable plan, the OA may develop and impose a mandatory POC.

Due to the nature of National Core Indicator (NCI) data being collected, no individual remediation is required for these measures. Guardian satisfaction surveys are anonymous. NCI data is a secondary data source for these measures.

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

The OA provides summary reports of remediation activities to the MA. Staff of the MA and OA review the reports on a quarterly basis as part of the Waiver Quality Management Committee (QMC) meetings. QMC meeting summaries document findings and remediation activities.

- ii. **Remediation Data Aggregation**

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

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

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

c. Timelines

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

No

Yes

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

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

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

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

Indicate whether Independence Plus designation is requested (select one):

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

The Waiver affords Waiver participants the opportunity to direct their services through employer authority and budget authority. The participant exercises choice and control over the workers who provide services. Participants also exercise decision-making authority and management responsibility for their budgets. Within the overall cost limit, the participants determine the type and amount of services to be purchased and establish rates for Personal Support Workers.

Participants are supported to direct their own services by the following entities:

Independent Service Coordination Agencies conduct case management services as an administrative activity under the Waiver, including person centered plan development and monitoring;

A fiscal employer agency that provides Financial Management Services as an administrative activity under the Waiver, including making payments on behalf of the employer, completing required tax and other withholding and documentation; and

A Information and Assistance in Support of Participant Direction provider, if selected through an optional direct service under the Waiver, who assists the participant (or the participant's family or representative, as appropriate) in arranging for, directing and managing services.

The participant receives information about participant-directed services and supports during the person centered planning process. Information is presented in both written and verbal formats to ensure the family understand the participant-directed option and can make an informed choice. Information is provided about decision-making budget authority up to the approved level of support. Specific information is provided about the roles and responsibilities of the parent or legal representative and the financial management services.

The participant does have the option of receiving agency-based services if desired.

The participant's choice of the type of supports is documented as part of the person centered plan. Service Agreements are completed for each provider selected to work with the Waiver participant.

If at any time the participant voluntarily decides he or she no longer wants to receive participant-directed services, the person centered plan will be revised to document the choice of agency-based services.

A participant may be involuntarily restricted from participant-directed services due to any of the following circumstances:

- The MA or the OA determines that the participant and/or his or her representative have committed fraud regarding participant-directed program funds;
- The participant is living with a family member or other individual who has been determined by Adult Protective Services or other authorized entity (e.g., law enforcement) to have abused or neglected the participant or other individuals; or
- The ISC agency and FMS have determined and documented that the participant and/or his or her employer of record are not able to direct their own services, either with or without the assistance of a Information and Assistance in Support of Participant Direction provider.

This restriction of participant-directed services by the State is subject to appeal to the MA. The outcome of the appeal process is final. In this event, agency-directed services would be made available and documented in the person centered plan. The ISC works with the service providers, the Information and Assistance in Support of Participant Direction provider (if applicable) and the OA as necessary to ensure service continuity and health and welfare during the transition.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

- Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- Waiver is designed to support only individuals who want to direct their services.**
- The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

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

Information is available for families that include guidelines for selecting personal support workers, information on financial management services, rights and responsibilities, and other requirements of the Waiver. The ISC assist's the participant and family to understand the service options available under the Waiver. The information is reviewed with participants at least annually as part of the individual person centered planning process.

Participants are given a handbook developed with input from families and other stakeholders that describes the benefits and potential liabilities of self-directed services.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

- The State does not provide for the direction of waiver services by a representative.
- The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Home Accessibility Modifications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Physical Therapy (Extended Medicaid State Plan)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Speech Therapy (Extended Medicaid State Plan)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Personal Support	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Emergency Home Response Services (EHRS)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Training and Counseling Services for Unpaid Caregivers	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Adaptive Equipment	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Vehicle Modification	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Behavioral Services (Psychotherapy and Counseling)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Temporary Assistance	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Behavior Intervention and Treatment	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Occupational Therapy (Extended Medicaid State Plan)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

- Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.**
Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

- FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

- FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The State conducted a Request for Proposal (RFP) process to select Financial Management Service (FMS) vendor(s). The OA developed the RFP for the FMS Vendor Fiscal option pursuant to Section 3504 of the IRS Code, IRS Revenue Procedure 70-6, and IRS Proposed Notice 2003-70m as well as OA rules and regulations.

The criteria used in selecting the vendor(s) included:

- Financial stability, with at least one year of experience in providing employer agent services to participants in similar participant-directed options.
- Ability to perform all functions in accordance with Federal, State and Department regulations and requirements.
- Ability to perform all functions directly without the use of a sub-agent.
- Ability to verify, process and pay invoices for goods and services approved in the participant's support plan in accordance with Operating Agency requirements.
- Ability to prepare and maintain a comprehensive FMS policy and procedure manual that reflects all tasks performed, Illinois-specific labor, tax and workers' compensation insurance requirements, as well as requirements of the Waiver.
- An internal quality management plan that demonstrates sufficient internal controls to monitor FMS performance.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The per member per month (PMPM) fee paid to the FMS private entities is established through the RFP competitive bid process. As of 7/1/17, the fee is 3.4% of the maximum service costs for one FMS and 4% for

the other FMS. This is a reasonable percentage compared to the scope of the supports specified in E-1-i-iii.

The PMPM fee for waiver participants is negotiated between the State and the successful bidders. The fee is claimed as an administrative fee under the Waiver

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- Assist participant in verifying support worker citizenship status**
- Collect and process timesheets of support workers**
- Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- Other**

Specify:

Assist with performing required background checks, abuse and neglect registry checks and any other required screenings. Verify independent Personal Support (domestic employee) provider qualifications. These functions are necessary for the proper and efficient administration of the waiver by reviewing and ensuring provider qualifications are met.

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant's participant-directed budget**
- Track and report participant funds, disbursements and the balance of participant funds**
- Process and pay invoices for goods and services approved in the service plan**
- Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- Other services and supports**

Specify:

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The FMS private entity(ies) must have internal monitoring procedures and processes to ensure contract performance compliance. The State reserves the right to monitor and track vendor performance over the course of the contract. The State will monitor the vendor(s) based on the performance measures approved in the waiver and any other contractual requirements. The vendor(s) agrees to provide all of the data specified

by the State for service payment and claiming purposes. The vendor(s) agrees to cooperate with the State on monitoring and tracking activities which may require the vendor to submit requested progress reports, allow unannounced inspections of its facilities, participate in scheduled meetings and provide management reports as requested by the State. The Operating Agency reviews performance on an annual basis. The Medicaid Agency participates in the review and the results of these reviews are shared with the Waiver Quality Management Committee.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home Accessibility Modifications	<input type="checkbox"/>
Physical Therapy (Extended Medicaid State Plan)	<input type="checkbox"/>
Supported Employment - Individual Employment Support	<input type="checkbox"/>
24-Hour Stabilization Services	<input type="checkbox"/>
Community Day Services	<input type="checkbox"/>
Residential Habilitation	<input type="checkbox"/>
Speech Therapy (Extended Medicaid State Plan)	<input type="checkbox"/>
Personal Support	<input type="checkbox"/>
Emergency Home Response Services (EHRS)	<input type="checkbox"/>
Training and Counseling Services for Unpaid Caregivers	<input type="checkbox"/>
Supported Employment – Small Group Supports	<input type="checkbox"/>
Adaptive Equipment	<input type="checkbox"/>
Vehicle Modification	<input type="checkbox"/>
Behavioral Services (Psychotherapy and Counseling)	<input type="checkbox"/>
Temporary Assistance	<input type="checkbox"/>
Adult Day Care	<input type="checkbox"/>
Information and Assistance in Support of Participant Direction	<input checked="" type="checkbox"/>
Behavior Intervention and Treatment	<input type="checkbox"/>

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Non-Medical Transportation	<input type="checkbox"/>
Occupational Therapy (Extended Medicaid State Plan)	<input type="checkbox"/>
Skilled Nursing	<input type="checkbox"/>

- Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

ISC agencies, under contract with the Operating Agency, are compensated through a per participant allocation that is standard statewide. ISC's were selected through a request-for-proposal (RFP) process. ISC's conduct assessments, develop the person centered plans with the participants, assist with linkage and applications for any non-Waiver services, inform participants of all willing and qualified providers, complete any necessary prior approval applications, ensure service plans are implemented, provide necessary coordination of services, explain and provide information about reporting abuse/neglect/exploitation, and explain appeal rights and assist in filing appeals as needed. Annually the Operating Agency conducts site visits at all ISC entities and reviews their performance using a representative sample of all waiver participants.

One or more Financial Management Service (FMS) entity/entities, under contract with the Operating Agency and selected through a request for proposal process, provides fiscal agent and employer agency services. The FMS entity is compensated on a per member per month basis. The Operating Agency reviews the performance of the FMS entity on an annual basis.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

A participant or their guardian, if one has been appointed, may choose to voluntarily terminate from participant-direction at any time. If the participant exercised employer authority, employees of the participant are typically provided with 30 days advance written notice of the termination, however, this notification is not mandatory. The participant selects a community agency to provide and direct needed Waiver services. These changes are discussed among those responsible for person centered planning. The plan is updated to reflect the change in service delivery method, the participant's or guardian's (when applicable) decision to terminate participant-direction, and the selected community agency(ies) that will now be delivering services. The ISC works with service providers and the

Operating Agency as necessary to ensure service continuity and health and welfare during the transition.

If the health and welfare of the participant cannot be assured on a long-term basis within the cost limit of participant-directed supports in combination with other natural supports and community resources, the participant will be considered for other service options within the Waiver, including other residential habilitation options. These limits were established through a review of historical expenditures.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

A participant may be involuntarily restricted from participant-directed services due to any of the following circumstances:

- The MA or the OA determines that the participant and/or his or her representative have committed fraud regarding participant-directed program funds;
- The participant is living with a family member or other individual who has been determined by Adult Protective Services or other authorized entity (e.g., law enforcement) to have abused or neglected the participant or other individuals; or
- The ISC agency and FMS have determined and documented that the participant and/or his or her employer of record are not able to direct their own services, either with or without the assistance of a Information and Assistance in Support of Participant Direction provider.

This restriction of participant-directed services by the State is subject to appeal to the MA. The outcome of the appeal process is final. In this event, agency-directed services would be made available and documented in the service plan. The ISC works with the service providers, the Information and Assistance in Support of Participant Direction provider (if applicable) and the OA as necessary to ensure service continuity and health and welfare during the transition.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
	Number of Participants	Number of Participants
Year 1	<input type="text"/>	<input type="text" value="6000"/>
Year 2	<input type="text"/>	<input type="text" value="6000"/>
Year 3	<input type="text"/>	<input type="text" value="6000"/>
Year 4	<input type="text"/>	<input type="text" value="6000"/>
Year 5	<input type="text"/>	<input type="text" value="6000"/>

Appendix E: Participant Direction of Services

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

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

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

- Recruit staff**
 Refer staff to agency for hiring (co-employer)
 Select staff from worker registry
 Hire staff common law employer
 Verify staff qualifications
 Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

The cost of required background checks is paid by the OA as part of the negotiated per member per month (PMPM) fee paid to Financial Management Service (FMS) private entities.

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
 Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
 Determine staff wages and benefits subject to State limits
 Schedule staff
 Orient and instruct staff in duties
 Supervise staff
 Evaluate staff performance
 Verify time worked by staff and approve time sheets
 Discharge staff (common law employer)
 Discharge staff from providing services (co-employer)
 Other

Specify:

Appendix E: Participant Direction of Services

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

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

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget**
- Determine the amount paid for services within the State's established limits**
- Substitute service providers**
- Schedule the provision of services**
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- Identify service providers and refer for provider enrollment**
- Authorize payment for waiver goods and services**
- Review and approve provider invoices for services rendered**
- Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Within the overall home-based supports cost limit, the person centered plan specifies the types of and amounts of covered services needed by the participant. For home-based supports, the maximum annual allocation is set by State law. At the time the law was passed, public hearings were held regarding its implementation. The annual allocation is tied to Social Security benefit levels which are indexed to the cost of living (as required by law).

Participants and the general public are made aware of the program budget amount in a variety of ways. For example, the Waiver Manual is available at the OA's website and contains this information. A Rate Table is also posted on the OA's website which outlines statewide rates for certain services. In addition, ISC's and Information and Assistance in Support of Participant Direction providers (if applicable) assist individuals in understanding and working within the annual and monthly cost allocations.

Individuals may request a fair hearing of any denial or reduction in services. The Waiver Manual contains information on individual rights and fair hearings. ISC's inform participants of their rights to appeal initially upon enrollment, annually as part of the person centered planning process and more often as needed.

For some services, statewide rates apply, such as Behavior Intervention and Treatment. For other services, the participant is given the authority to negotiate individual rates. A written Service Agreement is executed between each service provider, the participant or his or her guardian and the Information and Assistance in Support of Participant Direction provider (if applicable) The Service Agreement defines the terms of the

services to be provided including the effective date, the rate of payment, the maximum units of service to be provided each month and the maximum monthly charge. A copy of the Service Authorization for domestic employees is on file with the Financial Management Service (FMS) entity. Bills submitted in excess of the monthly and annual allocations are rejected for payment. This ensures that the combination of services received is consistent with the person centered plan and does not exceed the annual service cost limit.

The OA Rate Table is updated when rate adjustments are implemented, based on State appropriations.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Upon being authorized for Waiver services, the participant or guardian (when applicable) is informed in writing by the Operating Agency and in person by the ISC about the overall cost limit, participant-directed opportunities, and budget authority. Once services have begun, the participant or guardian (when applicable) is notified and kept informed of any adjustments to the overall amount by the Operating Agency and ISC. The participant and guardian (when applicable) works with the ISC to establish a budget as a part of the individual's plan. Adjustments may be made throughout the year as needed.

A service agreement form is completed annually to detail the individual's budget. This form may be modified throughout the course of the year as needed. This form is available upon request from the OA. Should any services be reduced or denied, the participant is notified of their right to appeal.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

- Modifications to the participant directed budget must be preceded by a change in the service plan.
- The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Participants and guardians, when applicable, may adjust person centered plans within the monthly allocation without prior review or approval by the State. Adjustments are made via the use of Service Agreements with providers and by updating the person centered plan. Changes in services are documented in the person centered plan and in revised Service Agreements. Changes in Service Agreements where the participant exercises budget authority are shared with the ISC for monitoring purposes. Changes in Service Agreements where the participant exercises employer authority are shared with the Financial Management Service (FMS) entity when services provided by domestic employees change.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

Per statute, adult home-based supports spending is limited on a monthly basis. Participants are encouraged by members of the person centered planning team to allocate authorized services throughout the month to avoid premature depletion of program funds. Edits in the electronic billing system prevent over expenditures. The OA's electronic transfer alerts the FMS of any units of service above the authorized services.

The ISC is responsible for monitoring person centered plan implementation and participant health and welfare, identify and address issues of concern, including the timely prevention of the premature depletion of the participant-directed budget or potential service delivery problems. The minimum frequency of contact for monitoring the plan's implementation, including direct, in-person contact with the participant, is annually. This annual monitoring visit is in addition to the direct contact for plan development.

The ISC (on a mid-year basis) reviews that the PCP is being fully implemented. Also, the OA, on a statistically valid sample basis, reviews that the PCP is being fully implemented.

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

ISC entities are responsible for informing participants of the right to appeal adverse decisions and actions upon Waiver enrollment. The Operating Agency has developed a standard form, Notice of Individual Right to Appeal (IL462-1202, 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.

ISC entities are also responsible for written notification when an adverse decision or actions occurs.

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 services are presented including the choice of HCBS as an alternative to institutional care, denying the service or the providers(s) of their choice and also upon notice of service denial, suspension, termination or reduction. Information about appeal rights is also available at any time upon request. 89 Ill. Admin. Code 104 and 59 Ill. Admin Code 120.110 describes the fair hearing request procedures in use for the Adult Developmental Disability Waiver.

Copies of notices are maintained in the individual's record by the ISC. 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.

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, is 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 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. Once a final decision is released by the Medicaid agency, it is reviewable only through the Circuit Courts of the State of Illinois.

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 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 via electronic communication and paper reports at the Quality Management Committee meetings. The data is analyzed and evaluated for trends on a quarterly and annual basis by the OA and MA. As individual problems and trends are identified, proactive remediation is initiated. The State establishes remediation plans by identifying the responsibilities of the Medicaid and Operating Agencies and identifying timeframes for completion. The Quality Management Committee collectively tracks the remediation activity.

The FMS entity/entities maintain a complaint log regarding issues concerning the payment of domestic employees. Summary data from the log is reported to and reviewed by the OA on a quarterly basis. This information is shared with and reviewed by the Quality Management Committee on an annual basis. Remediation is initiated and tracked as necessary. The State establishes remediation plans by identifying the responsibilities of the Medicaid and Operating Agencies and identifying timeframes for completion.

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 ISC 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 ISCs use the Rights of the Individuals form (IL462-1201) to document the notification. Options for filing complaints are also posted on the OA's website.

The type of complaints can include anything of concern to the participant or guardian, e.g., dissatisfaction with the participant's person centered plan, failure to implement the individual's person centered plan, quality of services or supports, risk of losing services, etc. In addition, individuals can identify and report issues that are program-wide and do not specifically apply to their individual services.

When a complaint is received, the OA will make an initial response to the individual making the complaint within two business days with the overall goal to resolve grievances within 30 days. Timeliness is tracked and monitored by the OA and reported regularly to the MA.

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 ISC's 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.

An OA staff person is assigned to each complaint. The assigned staff person confirms and/or collects information

from the ISC, provider(s), and any other parties involved. He or she then takes appropriate action steps depending upon the complaint. Final resolution is recorded in the log. Reports are produced twice monthly for managers within the OA to ensure open complaints are being addressed on a timely basis.

The data is analyzed and evaluated for trends on a quarterly and annual basis. The summary reports are regularly 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 State requires the reporting of alleged abuse, neglect, exploitation, and deaths of individuals receiving services in settings that are licensed, certified, or funded by the OA. These reports are sent to the OAs Office of Inspector General (OIG) for intake and investigation. Reports can be made by anyone having contact with the participant or otherwise aware of allegations. Employees within Independent Service Coordination agencies and providers are required to report allegations. Reports are made via phone calls to the OIG hotline: (800) 368-1463.

The terms abuse, neglect, exploitation, and deaths for individuals receiving services in settings that are licensed, certified, or funded by the OA, are defined in State statute and regulations. See 59 Ill. Adm. Code 50 at <http://www.ilga.gov/commission/jcar/admincode/059/05900050sections.html>.

Under this regulation, deaths must be reported within 24 hours from the time the death was first discovered or the reporter was informed of the death or within four hours if abuse or neglect is suspected. Required reporters must report allegations of abuse, neglect, or exploitation within four hours of initial discovery by the required reporter.

The State also requires the reporting of alleged abuse, neglect, and exploitation of individuals receiving supports in their own homes. These reports are sent to the State's Adult Protective Services unit for review and actions necessary to ensure the health and safety of the alleged victim. Reports are made by anyone having contact with the participant or otherwise aware of allegations. Employees within Independent Service Coordination agencies and providers are required reporters. Reports are made via phone calls to the Adult Protective Services Hotline: (866) 800-1409.

The terms abuse, neglect, and exploitation for individuals receiving services in settings that are licensed, certified, or funded by the OA are defined in State statute and regulations. See 89 Ill. Adm. Code 270 at <http://ilga.gov/commission/jcar/admincode/089/08900270sections.html>.

Under this regulation, “If any mandated reporter has reason to believe that an eligible adult, who because of disability or other condition or impairment is unable to seek assistance for himself or herself, has, within the previous 12 months, been subjected to abuse, neglect, or financial exploitation, the mandated reporter, shall, within 24 hours after developing such belief, report this suspicion...” [Quoted from enabling statute: 320 ILCS 20/4(a-5).]

In addition, the state requires the reporting of other critical incidents to the OA through its automated Critical Incident Reporting and Analysis System (CIRAS). The other critical incidents include deaths otherwise not reportable to OIG or APS, known injuries, law enforcement involvement, medical emergencies, missing individuals, peer-to-peer acts of aggression, unauthorized restraint, injuries of unknown origin, and unscheduled hospitalizations. Providers must report such incidents within two working days of discovering or being informed of the incident. Since the incidents reported through CIRAS do not involve allegations of abuse, neglect, or exploitation, providers are given more time to compile and report information ensuring it is complete and accurate for trend analysis. The manual for the CIRAS system is available from the OA upon request.

Upon entry of an incident into CIRAS, the electronic system automatically notifies the ISC agency of the report. ISCs use this information to effectively monitor the individual’s well-being and ensure any needed actions are taken. OA staff also receives notification upon entry of reports of missing person and law enforcement involvement. All types of reports are summarized and analyzed on a monthly basis by OA staff. The summary and analytical reports are shared with the MA on a quarterly basis.

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

Participants and/or his or her guardian (if one has been appointed) are informed by the ISC about protections from abuse, neglect, and financial exploitation. The information provided includes the process for reporting allegations to the Operating Agency’s Office of the Inspector General (OIG) and to the Adult Protective Services for those residing in their own homes. Participants and guardians are informed that anyone who suspects abuse, neglect or financial exploitation may report an allegation.

Information is provided in the Rights of the Individual form (IL462-1201) and is shared with the participant and guardian (if one has been appointed) upon enrollment and at least annually thereafter.

Information on the State's hotline is available on multiple websites and is also listed in the Waiver Manual (available on the OA's website). Instructions about reporting allegations, including the hotline, are also available on the OA website.

The OA Monitors and ensure participants and guardians have received appropriate information about reporting allegations of abuse, neglect and financial exploitation.

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

Allegations of Abuse, Neglect, or Exploitation in Settings Licensed, Certified, or Funded by the OA.

The Operating Agency (DHS) Office of Inspector General (OIG), which is a semi-independent entity that reports to both the Governor and the Secretary of DHS (the OA), has statutory authority to receive and investigate reports of alleged abuse, neglect and exploitation of adults with developmental disabilities served in settings licensed, certified, or funded by the OA.

Per 59 Ill. Adm. Code 50 (<http://www.ilga.gov/commission/jcar/admincode/059/059000500000300R.html>), OIG staff receiving the report of the allegation are responsible for assessing, based on the information received at intake, whether the allegation could constitute abuse, neglect or exploitation and whether OIG has the authority to investigate. OIG must make these assessments within one day after receiving the report.

Any allegations or investigations of reports of abuse, neglect and exploitation shall remain confidential until a final report is completed. The identity of any person as a complainant shall remain confidential in accordance with the

State's Freedom of Information Act [5 ILCS 140] or unless identification is authorized by the complainant. Information concerning diagnosis and treatment for alcohol or drug abuse shall be disclosed to OIG by community agencies only in accordance with federal regulations at 42 CFR Part 2. Information concerning tests for human immunodeficiency virus (HIV) and diagnosis and treatment for acquired immune deficiency syndrome (AIDS) shall be disclosed to OIG by community agencies only in accordance with the AIDS Confidentiality Act [410 ILCS 305]. All personal health related information contained in OIG investigative reports shall remain confidential in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191) (45 CFR 160, 162 and 164).

All investigations shall be conducted in a manner that respects the dignity and human rights of all persons involved.

After determining the finding in all cases, the OIG must notify the following parties of the finding:

- the complainant;
- the individual who was allegedly abused, neglected or exploited or his or her legal guardian (if applicable);
- the person alleged to have committed the offense; and
- the employer of the person alleged to have committed the offense (i.e., the qualified service provider).

Within 10 day of completion, copies of investigative reports are shared with the State's Human Rights Authority, the protection and advocacy organization (Equip for Equality), the OA, and the OAs licensing and certification bureau.

If an investigation results in a substantiated finding of physical abuse, sexual abuse, egregious neglect or financial exploitation, it shall result in the accused employee's identity and the OIG finding being reported to the Health Care Worker Registry.

Allegations of Abuse, Neglect, or Exploitation in Settings Not Licensed, Certified, or Funded by the OA.

The State's Adult Protective Services agency has statutory authority to receive and investigate reports of alleged abuse, neglect and exploitation of adults with developmental disabilities who are living in their own homes which are not licensed, certified, or funded by the OA.

Per 89 Ill. Adm. Code 270 (<http://ilga.gov/commission/jcar/admincode/089/089002700C02400R.html>), APS staff receiving the report of the allegation must assign a priority level to the report as follows:

- Priority one reports are reports of abuse or neglect in which the alleged victim is reported as being in serious physical harm or in immediate danger of death or serious physical harm. Priority one reports include, but are not limited to, alleged abuse resulting in fractures, head injuries, internal injuries, or burns; threats of serious injury or death; lack of basic physical necessities severe enough to result in freezing, serious heat stress or starvation; need for immediate, significant medical attention; and alleged sexual abuse that has occurred in the last 72 hours.
- Priority two reports are reports of abuse, neglect or exploitation in which the alleged victim is reported as being abused, neglected or exploited and the report taker has reason to believe that the consequences are less serious than priority one reports. Priority two reports include, but are not limited to, physical abuse involving scratches or bruises; inadequate attention to physical needs such as insufficient food or medicine; unreasonable confinement; and probability of liquidation or depletion of an alleged victim's income and assets.
- Priority three reports are reports of abuse, neglect or exploitation in which the alleged victim is reported as being emotionally abused by a caregiver or the alleged victim's financial resources are being misused or withheld and the report taker has reason to believe that there is no immediate threat of harm to the alleged victim.

The required time frames for each priority are 24 hours from the receipt of the report for priority one, 72 hours from the receipt of the report for priority two, and seven calendar days from the receipt of the report for priority three.

Completed reviews are shared with the OA within 5 days, which then provides copies to the applicable ISC agency within 5 days of receipt of the completed review.

Other Critical Incidents

Beyond allegations of abuse, neglect, and or exploitation addressed above, the OA requires its providers to report directly to the OA other types of critical incidents, including deaths otherwise not reportable to OIG or APS, known injuries, law enforcement involvement, medical emergencies, missing individuals, peer-to-peer acts of aggression, unauthorized restraint, injuries of unknown origin, and unscheduled hospitalizations. These reports do not include

allegations of abuse, neglect or exploitation. These incidents are reported via an electronic system. All reports are accepted. Upon receipt of a report, the electronic system automatically informs the ISC agency of the incident. In the case of law enforcement involvement or missing individuals, the ISC agency will work with the reporting provider to take necessary steps to ensure the individual's safety; otherwise, the ISC agency uses this incident information during the course of its routine monitoring activities, resolving any problematic issues and modifying Plans as necessary. The OA staff use the incident information to complete statewide summary and trend analyses to identify, address, and prevent potential abuse, neglect, and exploitation, as well as otherwise seek strategies to enhance the service delivery system.

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

The Operating Agency maintains a database of OIG allegations of abuse, neglect, financial exploitation and deaths and investigative findings.

If the OIG investigation substantiates abuse, neglect or financial exploitation, meaning a preponderance of the evidence supports that the abuse or neglect did occur, the provider is required to submit a Written Response within 30 days for approval by the OA. The Written Response must indicate what actions will be taken to address the issues identified. If a finding of physical abuse, sexual abuse or egregious neglect is substantiated, the perpetrator's name is placed on the Illinois Department of Public Health, Health Care Worker Registry.

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

The OA receives allegations of abuse, neglect and financial exploitation from OIG as reported by complainants to the OIG telephone hotline. These reports are received generally within 2 business days of the allegation being reported. Although OIG investigates, the OA program division reviews each allegation to determine whether action is warranted prior to completion of the OIG investigation.

The OA program division gathers information about the types of allegations, participant characteristics and providers to identify patterns and trends.

The OA program division monitors allegations on an ongoing basis. Summary and analytic reports are developed regarding allegations and findings. These reports are shared with the MA. Summary reports that do not contain confidential information are posted on the OA website.

Both the Medicaid Agency and the Operating Agency work together through the Waiver Quality Management Committee (QMC), which meets quarterly, to review performance measures on documentation of the notification to participants of the Rights of the Individual, the reporting of participant deaths, and critical incidents and follow-up methods.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

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

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

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

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

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

The Mental Health & Developmental Disabilities Code(405 ILCS 5/2-108)prohibits seclusion. Section 1-126 of the Code defines Seclusion as the sequestration by placement of a recipient alone in a room which he has no means of leaving. The restriction of a recipient to a given area or room as part of a behavior modification program which has been authorized pursuant to his individual services plan shall not constitute seclusion, provided that such restriction does not exceed any continuous period in excess of two hours nor any periods which total more than four hours in any 24 hr period and that the duration,nature & purposes of each such restriction are promptly documented in the recipient's record. Restraint may be used only as a therapeutic measure to prevent a participant from causing harm to himself or physical abuse to others.Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized.In no event shall restraint be utilized to punish or discipline a participant,nor is restraint to be used as a convenience for the staff. Providers are expected to teach appropriate alternative skills/behaviors to replace undesired behaviors,& use behavior intervention procedures that do not involve unnecessarily restricting the rights of waiver participants.Positive & reinforcing interactions between individuals & staff are the preferred method for reducing and/or eliminating undesired behavior in community programs.If less restrictive interventions fail or are not effective in preventing an individual from causing harm to self & others & the use of restrictive interventions is determined warranted,then the use of restrictive interventions is permitted as follows.

A behavior strategy must be developed by the community support team

The team discusses the proposed measures, identifying the risks & benefits

The team confirms that the benefits of the proposed restrictive intervention outweigh the risks involved

The plan is reviewed by the provider's behavior management committee,if one is in place

In all cases, the plan is reviewed & approved by the provider's human rights committee prior to implementation

The planning process must include documentation of prior attempts to use less restrictive or positive interventions & reason for the necessary use of the restrictive interventions to be included in the plan,as well as the circumstances in which the interventions may be implemented.

As part of the planning activities,the provider must develop a plan to reduce the reliance on restrictive interventions.

Examples of types of restrictive interventions that are permitted include:

Personal restraint

Time-out,(restriction of a recipient to a given area or room as defined above in this section in the first paragraph regarding seclusion)

Psychotropic medications

Restricted access to personal property

Enhanced supervision,&

restrictive activity participation

Except for emergencies, restraint may be employed only upon the written order of a physician,clinical psychologist,clinical social worker,or registered nurse with supervisory responsibilities.No restraint shall be ordered unless,after personally observing & examining the participant, the physician, clinical psychologist, clinical social worker,or registered nurse is clinically satisfied that the use of restraint is justified to prevent the participant from causing physical harm to himself or others. In no event may a restraint continue for longer than two hours unless within that time period a nurse or physician confirms, in writing, following a personal examination of the participant,that the restraint does not pose an undue risk to the participant's health in light of the participant's physical or medical condition.The order shall state the events leading up to the need for restraint & the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed & the clinical justification for that length of time. No order for restraint shall be valid for more than 16 hours.If further restraint is required, a new order must be obtained.

In the event there is an emergency requiring the immediate use of restraint,it may be ordered temporarily by a qualified person only where a physician, clinical psychologist, clinical social worker, or registered

nurse with supervisory responsibilities is not immediately available. In that event, an order must be obtained as quickly as possible, & the participant must be examined by a physician or supervisory nurse within two hours after the initial employment of the emergency restraint. Whoever orders restraint in emergency situations must document its necessity & place that documentation in the participant's record.

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

The person who orders restraint must inform the providers' chief executive officer or designee in writing of the use of restraint within 24 hours. The chief executive officer or designee must review all restraint orders daily & must inquire into the reasons for the orders for restraint by any person who routinely orders them.

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

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

Every provider that employs restraint must provide training in the safe and humane application of each type of restraint employed. The agency may not authorize the use of any type of restraint by an employee who has not received training in the safe and humane application of that type of restraint. Each agency in which restraint is used must maintain records detailing which employees have been trained & are authorized to apply restraint, the date of the training & the type of restraint that the employee was trained to use. Employees authorized to apply restraint must be a licensed registered professional nurse, a behavior therapist as defined in Appendix C, a QIDP as defined in federal regulations, or a DSP. A DSP must:

be age 16 or older,

have completed eight years of grade school or provide proof of ability to read at an 8th grade level successfully complete an approved DSP training program within 120 calendar days of hire or being assigned DSP responsibilities, &

be certified in First Aid and CPR through the American Red Cross or American Heart Association or hold current certification as an EMT

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

Whenever restraint is used, the participant must be advised of his/her right to have any person of his/her choosing, including the Guardianship and Advocacy Commission or the agency designated pursuant to the Protection and Advocacy for Developmentally Disabled Persons Act notified of the restraint. A participant who is under guardianship may request that any person of his/her choosing be notified of the restraint whether or not the guardian approves of the notice.

PCP Team Approval

Any restrictive intervention employed must be included in the participant's person centered plan and be approved as documented by signature of the participant or guardian (if one has been appointed) and responsible ISC. This planning process must include prior attempts to use less restrictive or positive interventions and reason for the necessary use of the restrictive interventions to be included in the plan, as well as the circumstances in which the interventions may be implemented. Staff are trained to recognize these circumstances and to implement the interventions consistently and correctly. The ISC must review the implementation of the plan, including the effectiveness and continuing need for restrictive interventions, at least during its annual monitoring visit and more frequently if required by the needs of the participant.

Human Rights Committee Approval

Providers are required to establish and maintain a human rights committee that is responsible for

reviewing & approving any restrictive intervention of a participant's rights, whether general rights or specific to behavior management. The committee must have at least five members. Membership must include:

person served by the provider and/or his or her family member or guardian,
interested citizens with no conflict of interest, and
provider employee(s).

No more than half of the members of the committee may be employed by the provider & at least one third of the members must be otherwise unassociated with the provider.

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

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

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

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

Behavior Management Committee Approval

Should an agency choose to do so, it may establish a separate behavior management committee, which reports to the human rights committee, to review the use of psychotropic medications, any medication used to manage behaviors, & any restrictive interventions used to manage behavior issues or to treat diagnosed mental illness. Membership of the behavior management committee must include persons qualified by training & experiences to evaluate published behavior management studies & the technical adequacy of proposed behavior management interventions. When medications to manage behavior issues are used, a professional qualified to evaluate their use must be a member of the committee.

Providers are required to report unauthorized use of restraint through the Critical Incident Reporting and Analysis System (CIRAS). The OA reviews a statistically valid sample of Waiver participants each year to detect unauthorized use of restraints. In completing this review, the OA reviews records; conducts on-site observations; & interviews staff, participants, and guardians.

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

The Operating Agency is responsible for overseeing the permitted use of restraints and ensuring that State safeguards concerning their use are followed.

The OA contracts with Independent Service Coordination (ISC) agencies to monitor the unauthorized use of restraints and restrictive intervention of participants. The ISC conducts annual visits to monitor the plan's implementation, including direct, in-person contact with the participant. The ISC's are QIDPs and are subject to mandatory reporting requirements.

ISC's monitor through on-site observations, interviews, and record reviews. Any potential abuse would be reported to the OIG or APS (if applicable).

Any findings of unauthorized use of restraint and seclusion, or of injuries to participants resulting from the use of restraint regardless of authorization, are required to be reported by the ISC entities to the OA via the OA's referral form. The referral must be sent to the OA within two business days. Findings are documented on the ISC Visiting Notes form, discussed with the provider and addressed as necessary. Addressing the findings may include reporting potential abuse to the appropriate entity (Office of Inspector General), working with the provider to develop or modify behavior plans and/or any additional action that may be appropriate to the specific circumstances.

The OA tracks and analyzes reports received from ISC agencies. The OA maintains a Service Issues Log for this purpose. Summary and analytical data is produced from the log on a quarterly basis and shared and discussed with the MA. In addition to ensuring individual issues are resolved, the OA and MA identify system issues and implement enhancements when necessary.

Providers are required to report unauthorized use of restraint, including any instances not in compliance with State regulations, through the Critical Incident Reporting and Analysis System (CIRAS). The OA reviews a statistically valid sample of Waiver participants each year to detect unauthorized use of restraints, also identifying any service implementation issues such as over use or inappropriate or ineffective use of restraint. In completing this review, the OA reviews records; conducts on-site observations; and interviews staff, participants, and guardians.

Appendix G: Participant Safeguards

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

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

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

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

The Operating Agency is responsible for detecting the unauthorized use of restrictive interventions and ensuring that State safeguards concerning their use are followed.

The OA contracts with the Service Coordination (ISC) agencies to monitor the unauthorized use of restraints, seclusion and restrictive intervention of participants. The Independent Service Coordination (ISC) conducts annual visits. The ISC's are QIDPs and are subject to mandatory reporting requirements.

The ISC's monitor through on-site observations, interviews, and record reviews. Any potential abuse would be reported to the OIG.

Any findings of unauthorized use of restraint, seclusion and restrictive interventions, or of injuries to participants resulting from the use of restraint regardless of authorization, are required to be reported by the ISC entities to the OA via the OA's referral form. The referral must be sent to the OA within two business days. Findings are documented on the ISC Visiting Notes form, discussed with the provider and addressed as necessary. Addressing the findings may include reporting potential abuse to the appropriate entity (Office of Inspector General), working with the provider to develop or modify behavior plans and/or any additional action that may be appropriate to the specific circumstances.

The OA tracks and analyzes reports received from ISC's. The OA monitors both the provider and ISC activities thorough these reports, identifies additional remediation needs, and develops and implements systemic changes when necessary.

The OA monitors through a representative sample of participants on a continuous and ongoing basis. On-site reviews consist of record reviews, interviews with participants and staff, and observations. Identification of any unauthorized use of restraint, seclusion or restrictive intervention by a provider is subject to corrective action.

The OA collects data on the reporting of critical incidents and restrictive interventions as outlined in Appendix G - Performance Measures. The data is summarized and presented at the Waiver Quality Management Committee (QMC) meetings. The QMC meets quarterly. The MA and the OA reviews summary data, remediation activities and identifies trends over time as well as the effectiveness of policies and procedures.

The use of restrictive interventions is permitted during the course of the delivery of waiver services
Complete Items G-2-b-i and G-2-b-ii.

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

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

Appendix G: Participant Safeguards

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

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

The State does not permit or prohibits the use of seclusion

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

The Operating Agency is responsible for detecting the unauthorized use of seclusion and ensuring that State safeguards concerning their use are followed.

The OA contracts with Independent Service Coordination (ISC) agencies to monitor the unauthorized use of restraints, seclusion and restrictive intervention of participants. The Independent Service Coordination (ISC) conducts annual visits. The ISC's are QIDPs and are subject to mandatory reporting requirements.

The ISC's monitor through on-site observations, interviews, and record reviews. Any potential abuse would be reported to the OIG.

Any findings of unauthorized use of restraint and seclusion, or of injuries to participants resulting from the use of restraint regardless of authorization, are required to be reported by the ISC entities to the OA via the OA's referral form. The referral must be sent to the OA within two business days. Findings are documented on the ISC Visiting Notes form, discussed with the provider and addressed as necessary. Addressing the findings may include reporting potential abuse to the appropriate entity (Office of Inspector General), working with the provider to develop or modify behavior plans and/or any additional action that may be appropriate to the specific circumstances.

The OA tracks and analyzes reports received from ISC's. The OA monitors both the provider and ISC activities thorough these reports, identifies additional remediation needs, and develops and implements systemic changes when necessary.

The OA monitors through a representative sample of participants on a continuous and ongoing basis. On-site reviews consist of record reviews, interviews with participants and staff, and observations. Identification of any unauthorized use of restraint or seclusion by a provider is subject to corrective action.

The OA collects data on the reporting of critical incidents and restrictive interventions as outlined in Appendix G - Performance Measures. The data is summarized and presented at the Waiver Quality Management Committee (QMC) meetings. The QMC meets quarterly. The MA and the OA reviews summary data, remediation activities and identifies trends over time as well as the effectiveness of policies and procedures.

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

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

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

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

- a. Applicability.** Select one:

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

- b. Medication Management and Follow-Up**

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

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

59 Ill. Adm. Code 116 requires that Residential habilitation providers must have a registered professional nurse, advanced practice nurse, physician licensed to practice medicine in all of its branches, or physician assistant on duty or on call at all times. At least quarterly, this professional reviews medication orders, medication labels and Medication Administration Records (MAR) to ensure that medication labels and medications administered match those ordered. A part of this review includes review of the appropriateness and effectiveness of medications.

Licensing rule 89 Ill. Adm. Code 115 requires that participants in the residential setting who are receiving prescription medications must be seen by the prescribing physician every six months to review the medication use, and every three months if receiving psychotropics. A psychiatrist will either review psychotropic medications or be available for consultation when psychotropic medications have been prescribed.

A physician or pharmacist shall make available to employees, family and participants information on expected consequences, potential benefits and side effects of any prescribed medication.

For participants receiving psychotropic medications, a screening for and documentation of abnormal involuntary movements, including tardive dyskinesia, is completed at least every six months by a licensed health care professional or a person trained in performing this type of assessment.

Use of medications to modify or control behaviors or treatment of mental illness is considered to be a restrictive intervention. As such, it is also subject to the provider requirements for oversight by a properly constituted human rights committee as described in G-2.

During its licensure surveys, the OAs licensure unit reviews whether that the required supervision and assessments by licensed professionals described above occur within the time frames required by rule. In addition, registered professional nurses employed by the OA conduct on-site visits to ensure compliance with 59 Ill. Adm. Code 116 regarding the review of all medications, including behavior modifying medications. These reviews include, but are not limited to, physician oversight, nursing supervision, administration, record-keeping, storage, disposal, errors, and harmful or unsafe practices. The protocol used by the licensure teams and the protocol used by the nurses are available upon request from the OA.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Residential providers subject to medication administration requirements are monitored by the OA for compliance. Providers are required to track all medication errors and to report to the OA all errors with an adverse outcome (defined as requiring medical attention).

Per Title 59 Illinois Administrative Code Part 116, a medication error shall be immediately reported to the registered professional nurse, advanced practice nurse, physician, physician assistant, dentist, podiatrist or certified optometrist to receive direction on actions to be taken. All medication errors shall be documented in the individual's clinical record and a medication error report shall be completed within eight hours or before the end of the shift in which the error was discovered, whichever is earlier. A copy of the medication error report shall be maintained as part of the agency's quality assurance program.

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

In addition, the OA annually conducts on-site reviews of a representative sample of waiver participants annually. The OA team includes Registered Nurses. The team reviews participant medication regimen, medication administration, and compliance with rules applicable to medication management and administration.

The OA monitors for the following: written policies and procedures on reviewing adverse drug reactions; written policies and procedures on the review of medication errors; whether a medication error report is made for every medication error noted on the MAR; whether a review of medication administration is conducted by the nurse-trainer on a quarterly basis and that medication labels and MARs match the physician order sheets; and whether medications are being administered as prescribed and whether refusals are documented properly; and whether medication errors are reviewed by the nurse-trainer within 7 days of each occurrence.

When findings are discovered, the provider is required to develop a corrective action plan subject to the approval of the OA. The remediation must address the individual finding(s) as well as any other similar practices involving other individuals served by the provider. The provider must develop a quality assurance process to prevent future occurrences.

If serious findings are discovered, an immediate corrective action can be required (meaning remediation must occur before the OA reviewer exits the provider) or within a short time frame no more than 48 hours of the completion of the review. Plans to safeguard the welfare of participants until corrective action is implemented can include increased monitoring visits, or moving waiver participants either temporarily or permanently to other settings.

OA findings are summarized and reported to the Waiver Quality Management Committee (QMC) which includes key staff from the OA and MA. The Waiver QMC meets quarterly and develops appropriate system improvements in response to identified trends and concerns. The QMC meeting summary is a record of system improvements and outcomes.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

When medications are provided or employees of a waiver Residential Habilitation provider supervise their administration, the provider must ensure that such medications are provided and their administration is supervised in accordance with the Illinois Nursing and Advanced Practice Nursing Act (225 ILCS 65). Waiver Residential Habilitation service providers may allow non-licensed direct support persons to administer medications as long as the provider complies with the Administration of Medication in Community Settings rule (59 Ill. Adm. Code 116). Developmental Training providers may not allow non-licensed direct support persons to administer medications.

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

A competent medical professional must evaluate the ability of the participant to self-administer medications. Ability to self-administer medication must be reassessed at least annually. Participants must be evaluated using Department approved screening and assessment tools, in accordance with 59 Ill. Adm. Code 116.

A physician must provide the written order for a waiver participant to self-administer medications or participate in a self-administration of medication training program based on the results of the participant's evaluation. The order must become part of the individual record.

The provider must ensure and document the following:

- A physician must be responsible for the medical services provided to participants, and the management of participants' medications.
- Only a competent medical professional, that is, a physician licensed pursuant to the Medical Practice Act, advanced practice nurse licensed pursuant to the Nursing and Advanced Practice Nursing Act, and physician's assistant licensed pursuant to Physician Assistant's Practice Act, may prescribe and monitor all prescription medications.
- All medications, including patent or proprietary medications, e.g., cathartics, headache remedies, or vitamins, may be given only upon the written order of a competent medical professional. Rubber stamp signatures are not acceptable. All orders must be given as prescribed by the competent medical professional and at the designated time. A registered professional nurse or licensed practical nurse may take telephone orders. All orders must be immediately signed by the nurse taking the order and placed in the participant's record. These orders must be countersigned or documented by facsimile prescription by the competent medical professional within ten working days.

Administrative Rule 116 permits a registered nurse who has successfully completed the Operating Agency/DHS-approved nurse-trainer course for medication administration in the community (5 hours) to authorize direct support personnel to administer medication in residential sites. Authorized direct support

personnel must be at least eighteen, have completed high school or G.E.D., demonstrate functional literacy, and have successfully completed 8 hours of classroom training on medication administration. In addition, competency-based training is required specific to the participant, the medication and the dosages. Direct support personnel are authorized to administer only those specific medications to specific participants for which they have successfully completed training and competency evaluations. Authorized direct support personnel are re-evaluated by a nurse-trainer at least annually to ensure competency to administer each medication to each participant.

The MAR for the current month must be kept with the medications or in participant's record. The MAR must be completed and initialed immediately after the medication is administered. Each MAR must have a section that contains the full signature and title of each person who initials it. All changes in medication must be noted on the MAR by a nurse, physician, physician assistant, dentist, podiatrist, or certified optometrist and shared with administering staff prior to the next dose. Participant refusal to take medication must be noted on the MAR and in the individual record.

An individual Medication Administration Record (MAR) must be kept for each participant for medication administered. It must contain at least the following:

- 1) the participant's name;
- 2) the name and dosage form of the drug;
- 3) the name of the prescribing physician, physician assistant, advanced practice nurse, dentist, podiatrist, or certified optometrist;
- 4) dose;
- 5) frequency or times of administration;
- 6) route of administration;
- 7) date and time given;
- 8) most recent date of the order;
- 9) allergies to medication; and
- 10) special considerations.

For waiver participants who are independently self-administering medications, no MAR is required; however, the provider must track and document that the medications are being taken by the participant.

iii. Medication Error Reporting. *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**

Complete the following three items:

- (a) Specify State agency (or agencies) to which errors are reported:

Medication errors are defined in 59 Ill. Adm. Code 116 as: The administration of medication other than as prescribed, resulting in the wrong medication being given; or medication being given at the wrong time, in the wrong dosage, via the wrong route, or by the wrong person; or medication omitted entirely. It is meant to include a lack of documentation of medication administration or any error in that documentation.

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

Waiver Residential Habilitation providers are required to record all medication errors.

Medication errors are defined in 59 Ill. Adm. Code 116 as: The administration of medication other than as prescribed, resulting in the wrong medication being given; or medication being given at the wrong time, in the wrong dosage, via the wrong route, or by the wrong person; or medication omitted entirely. It is meant to include a lack of documentation of medication administration or any error in that documentation.

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

Any medication error that results in an adverse outcome is reported to the OA within seven calendar days.

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

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

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

Residential providers subject to medication administration requirements are monitored by the OA for compliance. Providers are required to track all medication errors and to report to the OA all errors with an adverse outcome (defined as requiring medical attention).

The OA reviews a representative sample of waiver participants annually. The OA team includes Registered Nurses. The team reviews participant medication regimen, medication administration, all medication errors, and compliance with rules applicable to medication management and administration.

The OA monitors for the following: written policies and procedures on reviewing adverse drug reactions; written policies and procedures on the review of medication errors; whether a medication error report is made for every medication error noted on the MAR; whether a review of medication administration is conducted by the nurse-trainer on a quarterly basis and that labels match the physician order sheets; and whether medications are being administered as prescribed and whether refusals are documented properly; and whether medication errors are reviewed by the nurse-trainer with 7 days of each occurrence.

A medication error shall be immediately reported to the registered professional nurse, advanced practice nurse, physician, physician assistant, dentist, podiatrist or certified optometrist to receive direction on actions to be taken. All medication errors shall be documented in the individual's clinical record and a medication error report shall be completed within eight hours or before the end of the shift in which the error was discovered, whichever is earlier. A copy of the medication error report shall be maintained as part of the agency's quality assurance program.

In addition to the review of all medication errors through its statistically valid sample of waiver participants, as well as its review of providers' written policies and procedures on the review of medication errors, any medication error that results in an adverse outcome is reported to the OA within seven calendar days. All reports are reviewed by the OA and followed up as necessary to ensure that adequate safeguards are in place to prevent future occurrences.

When findings are discovered, the provider is required to develop a corrective action plan subject to the approval of the OA. The remediation must address the individual finding(s) as well as any other similar practices involving other individuals served by the provider. The provider must develop a quality assurance process to prevent future occurrences.

If serious findings are discovered, an immediate corrective action can be required (meaning remediation must occur before the OA reviewer exits the provider) or within a short time frame no more than 48 hours of the completion of the review. Plans to safeguard the welfare of participants until corrective action is implemented can include increased monitoring visits, or moving waiver participants either temporarily or permanently to other settings.

OA findings are summarized and reported to the Waiver Quality Management Committee (QMC) which includes key staff from the OA and MA. The Waiver QMC meets quarterly and develops appropriate system improvements in response to identified trends and concerns. The QMC meeting summary is a record of system improvements and outcomes.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent 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 The number and percent of participant records reviewed that documented the participant (and/or guardian) received information/education about how to report abuse, neglect, exploitation & 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 representative sample.

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 Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <div style="border: 1px solid gray; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

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

Data Aggregation and Analysis:

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

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

Performance Measure:

G3 In response to OIG substantiated abuse, neglect or financial exploitation investigations, the number and percent of written responses received from the provider and approved by the OA within 60 calendar days of completion of OIG investigation report. N: Number of written responses approved by the OA within required time frames. D: Total number of substantiated investigations.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

Performance Measure:

G4 The number and percent of reportable deaths with substantiated claims of abuse and/or neglect that were reported within the required timelines. N: Number of reportable deaths with substantiated claims of abuse and/or neglect reported within the required timelines. D: All reportable deaths with substantiated claims of abuse and/or neglect.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA (DHS) Office of Inspector General (OIG) and Medicaid eligibility file.

Responsible Party for data collection/generation <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 checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

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

Performance Measure:

G5 Number and percent of reported deaths with substantiated claims of abuse and/or neglect for which corrective measures were appropriately taken by the OA. N: Number of reported deaths with substantiated claims of abuse and/or neglect for which corrective measures were appropriately taken by the OA. D: Total number of reported deaths with substantiated claims of abuse and/or neglect.

Data Source (Select one):

Program logs

If 'Other' is selected, specify:

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

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

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

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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 healthcare services identified in their person centered plan.
Numerator: Number of participants reviewed who received support to access healthcare services. Denominator: Number of participants in the sample with healthcare services identified in their PCP.

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 Confidence Interval = 95%

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <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 MA will utilize numerous methods to ensure oversight of Quality Assurance, Quality Improvement and the Health and Welfare of waiver participants. The MA will work with the OA to flag providers at risk of sanction or licensure action due to deficient practices by developing a management information tool to allow for review and analysis of QIO on-site record, remediation verification and unannounced on-site reviews of waiver providers.

The MA will also require the OA to provide notification of actions taken to remediate QIO report findings. The MA will review, analyze and update the existing critical incident reporting procedures for waiver participants.

The MA will require the OA to timely report substantiated incidents of waiver participant abuse, neglect, serious injury or unexplained death.

The MA will establish regular communication with Illinois Department of Aging’s Adult Protective Services program and the Department of Human Services’ Office of Inspector General to develop a process to ensure timely receipt of complaints, allegations and investigations regarding waiver participants.

All of these additional measures are a part of the AA CAP. Many of these measures are already utilized or are in the development process. The processes that are being developed will have a completion date of 3/31/18.

The MA is in constant communication with the OA. The formal discussions, analysis and oversight of the OA occurs during the twice per quarter, Waiver Review meeting.

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 individual remediation. A POC is submitted by the provider to the OA for approval within 14 days of notification to provider of findings that cannot be corrected immediately while the reviewers are on site. The POC must correct the findings within 60 calendar days, other than those corrected immediately while the reviewers are on site. In instances of serious findings the provider may be directed by the OA to correct a finding in a much shorter time frame, including instances of immediate correction, where appropriate. In instances where the provider fails to submit a plan or when the provider fails to submit an acceptable plan, the OA may develop and impose a mandatory POC.

The OA is responsible for individual remediation of provider failure to report deaths subject to required reporting. Upon discovery, the death is reported to the OA Office of Inspector General (OIG) within the required time frame. Depending on the specific circumstances identified, a POC may be required. See above for description of OA Plan of Correction (POC) process.

The OA is responsible for reviewing and approving written responses from providers. A written response is submitted by the provider to the OA for approval within 60 calendar days of completion of the OIG investigation report. In instances where the provider fails to submit a written response within the required time frame and/or when the provider fails to submit an acceptable WR, the OA imposes a mandatory corrective action plan.

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

The OA provides quarterly reports of findings and remediation activities to the MA. Staff of the MA and OA review the reports on a quarterly basis as part of the Waiver Quality Management Committee (QMC) meetings. The QMC meeting summaries document the actions taken.

ii. Remediation Data Aggregation

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

Responsible Party <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 type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually
Specify:	
<input type="text"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other
	Specify:
	<input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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.

Appendix H: Quality Improvement Strategy (1 of 2)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

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

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The OA currently receives and maintains data from the Abuse/Neglect/Exploitation database and the Complaint database, and the Critical Incident Reporting and Analysis System database. Data from these three sources are combined using common data fields. Summary information and trend analysis is discussed during quarterly Quality Management Committee meetings of the MA and OA staff. Necessary remediation is identified and documented on the System Improvement Log.

The Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency (MA), and the Illinois Department of Human Services, Division of Developmental Disabilities, as the Operating Agency (OA), work in partnership to evaluate the waiver Quality Management System (QMS) and to analyze the information derived from discovery and remediation activities for each of the assurances.

The OA is responsible for almost all of the data collection to address the Quality Management System discovery and remediation sections located the Appendices. The State's system improvement activities are in response to aggregated and analyzed discovery and remediation data collected on each of the assurances.

The sources of discovery evidence vary, but all are based on either a 100 % or the representative sampling methodology as indicated for each performance measure. The OA annually selects a representative sample of waiver participants. Onsite reviews are scheduled and conducted throughout the year at Independent Service Coordination and direct service providers. Data is collected throughout the year and individual problems are remediated as they are identified. The MA participates in select reviews with the OA team as part of MA oversight and quality assurance. Other data sources include the State information system and other reports as indicated in the waiver.

The Adults with Developmental Disabilities waiver Quality Management System (QMS) plan is part of an overall quality management plan for the three 1915 (c) waivers operated by the DHS, Division of Developmental Disabilities (OA). The other waivers include the Children's Support Waiver (0464), and the Children's Residential Waiver (0473). While some data may be collected during the same on-site provider reviews, the sample for each waiver is drawn separately and the results aggregated separately.

The OA conducts a Quality Management Committee (QMC) meeting with the MA each quarter to review data collected from the previous quarter and for the year to date. Data to be collected semi-annually or annually are reported as indicated by the performance measure in the waiver. All reports are provided to MA for review prior to the quarterly meetings. Annual reports are produced identifying trends based on the full representative sample and/or 100% review of data.

The OA reports on all data collected for the three developmental disabilities waivers, however data is reported separately, by waiver. Data is reported by individual performance measure and in total for comparison to all performance measures. Individual performance measure reports include timeliness of remediation based on immediate, 30, 60, 90 day increments and remediation outstanding.

The MA and OA identify trends based on scope, severity, changes and patterns of compliance. Identified trends are discussed and analyzed regarding cause, contributing factors and opportunities for system improvement. Suggestions for system changes are added to the OA's Waiver QMC System Improvement

Log for tracking purposes. Decisions and timelines regarding system improvement are made based on consensus of priority and specific steps needed to accomplish change. To assist in the development and evaluation of system improvement strategies, the State seeks input from stakeholders. The OA Quality Committee made up of participants and family members, providers, advocates and other interested parties meets to provide advise to the OA about proposed system design changes. The MA is a member of the Quality Committee.

ii. System Improvement Activities

Responsible Party <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 checked="" type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Other Specify: <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 processes Illinois follows to continuously evaluate, as appropriate, effectiveness of the QMS are the same as the processes to evaluate the information derived from discovery and remediation activities. The Waiver Quality Management Committee (QMC) System Improvement Log is a dynamic product that is discussed quarterly by key staff of the MA and the OA regarding progress, updates and evaluation of effectiveness. Effectiveness is measured by impact on performance based on ongoing data collection over time, feedback from participant/guardian interviews, surveys, and service providers. Multiple years of data collection will allow the State to evaluate the effectiveness of system improvements over time. One meeting of the Waiver QMC each year is partly devoted to an overview of the previous year's activities and a discussion of whether changes are needed to the Quality Management Strategy. System design changes may be specific to one waiver or may involve multiple waivers.

The State provides information about the results of system improvement activities to stakeholders, including participants and guardians, family members, waiver service providers, advocates and other interested parties by developing summary reports, program Information Bulletins and/or waiver manual updates. Information is continually posted on the OA website. Providers and advocacy organizations are informed via electronic mail as Information Bulletins, manual updates and training curriculum modifications are made available. Private individuals can submit their email addresses on line to the OA and be added to the list serve to receive electronic information as well. When indicated, the OA also conducts informational webinars regarding policy and procedure changes.

Quarterly, the OA posts a summary report of the results of the waiver performance measures on its website.

The Operating Agency (OA) posts on its website information on each agency regarding licensure and quality assurance survey results; licensure and contract status; and substantiated findings of abuse, egregious neglect, and exploitation.

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

Each year, one meeting of the Waiver QMC is partly devoted to an overview of the previous year's activities and a discussion of whether changes are needed to the overall Quality Improvement Strategy. At the meeting, the MA and OA discuss whether to make changes in existing performance measures, add measures or discontinue measures. The State continually strives to increase the compliance rate of each performance. While the target compliance rate for each performance measure is 100%, the State realizes that it may take multiple system changes over several years to reach the goal of 100% compliance.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Provider agencies that are under contract with the Operating Agency and receive over \$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 person centered 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). 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:

II Number and percent of reviewed waiver service claims submitted for FFP that are specified in the participant's person centered plan. N: Number of claims reviewed that were specified in the PCP. D: Total number of claims in the representative sample.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA Comparison of claims with person centered plans in sample

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<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"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 checked="" type="checkbox"/> Operating Agency <input type="checkbox"/> Sub-State Entity <input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input checked="" type="checkbox"/> Annually <input checked="" type="checkbox"/> Continuously and Ongoing <input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

I2 Number and percent of waiver service claims reviewed that were submitted for participants who were enrolled in the waiver on the date that the service was delivered. N: Number of claims submitted for participants who were Medicaid eligible on the date the service was provided. D: All waiver claims.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA MIS automated reports

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

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

Performance Measure:

I3 Number and percent of waiver claims reviewed that were submitted using the rate developed in accordance with the rate methodology approved waiver. **N:** Number of claims with correct rate. **D:** All claims in representative sample.

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 Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <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 type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

I4 Number and percent of waiver claims reviewed that were confirmed to have been provided. N: Number of claims reviewed with required documentation of service delivery. D: All claims in representative sample.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA Comparison of claims with approved rates

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

	<input type="button" value="↑"/> <input type="button" value="↓"/>
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid gray; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid gray; height: 20px; width: 100%; margin-top: 5px;"></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.

The Medicaid Agency (MA) conducts select reviews as part of MA oversight and quality assurance.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The OA is responsible for seeing that individual issues are resolved.

38I: Upon discovery, the OA analyzes claims processing logic to identify errors and correct claim rate errors on both an individual and systemic level (to prevent repeat errors).

39I: Upon discovery, determination of waiver eligibility and if participant is eligible, no further action. If participant is ineligible, adjust claim.

40I: Upon discovery, if the provider is no longer providing services or the participant is no longer receiving services, no further action is taken. If the participant is still actively receiving services, request a copy of the current PCP to determine if the need for the service is addressed. If the services are needed and addressed in the current PCP, no further action is taken. If the services are needed and not included in the current PCP, require an updated PCP from the ISC. If the service is not needed by the participant, terminate the service.

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

The OA provides summary reports of remediation activities to the MA. Staff of the MA and OA review the

reports on a quarterly basis as part of the Waiver Quality Management Committee (QMC) meetings. QMC meeting summaries document the actions taken.

ii. Remediation Data Aggregation

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

Responsible Party <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 type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other 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 Financial Accountability that are currently non-operational.

- No**
- Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rate determination methods for each waiver service are outlined below.

Adult Day Care

The Adult Day Care rate is based on the rate used by the Illinois Department on Aging in their Waiver program for elderly persons, adjusted to include a transportation factor based on the Department on Aging’s transportation rate.

Residential Habilitation

Community-Integrated Living Arrangement (CILA) rates have been calculated using individualized model rate methodologies since 1994. The models (24 hour, host family, intermittent and family) fund components based on individual needs and the size of the home. Rates are based on system-wide provider cost data where possible and proxy values where necessary or appropriate. Rates have been subject to cost of living adjustments when enacted. Community Living Facility (CLF) and some CILA rates from legacy programs are calculated based on past

individual provider cost reports. Rates are subject to cost of living adjustments when enacted and may be adjusted based on rate appeals.

Community Day Services

The statewide, standard fee-for-service hourly rate is based on allowable costs from historical grant-funded site-based Developmental Supports. It includes the following components:

- Direct Support Staff Wages;
- Direct Support Staff Supervision;
- Employment Related Expenditures, e.g. benefits, FICA, Unemployment Insurance, Workers' Compensation Insurance;
- Professional Support Staff;
- Program Related Supplies, e.g., program materials, printing;
- Transportation Costs, e.g., vehicle operation costs, vehicle maintenance, insurance;
- Ownership/Occupancy Costs (Property Insurance, Maintenance costs, Utilities; and
- Administrative Overhead costs, e.g., Administrative Salaries, Office Space, Staff Training Costs, other allocated overhead.

Supported Employment - Individual Employment Support and Supported Employment – Small Group Supports

The statewide, standard fee-for-service hourly rate is based on allowable costs from historical grant-funded Supported Employment Programs. It includes the following components:

- Job Coach Staff Wages;
- Job Coach Staff Supervision;
- Employment Related Expenditures, e.g. benefits, FICA, Unemployment Insurance, Workers' Compensation Insurance;
- Professional Support Staff;
- Program Related Supplies; program materials, printing;
- Transportation Costs, e.g., vehicle operation costs, vehicle maintenance, insurance; and
- Administrative Overhead costs, e.g., Administrative Salaries, Office Space, Staff Training Costs, other allocated overhead.

Personal Support/Temporary Assistance Services

Rates for Personal Support and Temporary Assistance are negotiated between the participant, guardian (as applicable) or representatives and the providers with assistance from the Information and Assistance in Support of Participant Direction provider. The negotiated rates are specified in the Service Agreement and are subject to review and approval by the Operating Agency on either a targeted or sample basis. These rates are not subject to cost of living adjustments.

Home and Vehicle Modifications, Adaptive Equipment (including Assistive Technology)

Rates are usual and customary. Payments are subject to prior approval by the Operating Agency. Two bids are required for approval. Per-participant five-year cost limits and specific cost limits on rental housing governing the use of these services.

Non-medical Transportation

Statewide mileage rates are set by the Operating Agency. Per-trip rates are usual and customary charges. The rate is subject to cost of living adjustments when enacted by the General Assembly and signed by the Governor.

Emergency Home Response Services

The statewide rates for installation and monthly basic service are adopted from the rates established in October 2006 by the Department on Aging for their elderly waiver program.

Training and Counseling For Unpaid Care Givers

The counseling rate for unpaid care givers is identical to the standard statewide rate currently used in the waiver for participants receiving Individual Counseling services. The rate is based on available cost data for licensed social workers on contract with traditional developmental disabilities agencies. The rate is subject to cost of living adjustments when enacted. Reimbursement for training for unpaid care givers is based on usual and customary charges for the tuition or fees to attend the program. Transportation, meals and lodging to attend training are not included. Reimbursement for training for unpaid care givers is not subject to cost of living adjustments.

Behavior Intervention and Treatment

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

Behavioral Services (Psychotherapy and Counseling) and Skilled Nursing

These rates are based on available cost data for clinical psychologists, social workers and nurses on contract with traditional developmental disabilities agencies. The rates are subject to cost of living adjustments when enacted.

Physical Therapy, Occupational Therapy, and Speech Therapy

These rates are based on rates for these services in the Medicaid State Plan, converted to an hourly rate.

Information and Assistance in Support of Participant Direction

This a standard, statewide, hourly fee-for-service rate.

24-Hour Stabilization Services

The rates for this service are initially established through a Request for Applications process. Through this process, the State compares the proposed rates of willing providers. A standard methodology is developed for the waiver service with variation based upon a number of factors defined below. The required components that are used to establish the rate are:

- Direct support staff wages;
- Professional staff wages and clinical contracts, e.g., QIDPs, Behavior Analysts, nurses, etc.;
- Employment-related expenditures, e.g., employee benefits, FICA, unemployment insurance, workers' compensation, etc.;
- Program-related expenditures, e.g., supervision, supplies, etc.;
- Utilization factors;
- Administration, e.g., administrative salaries, staff travel, office space and expenses; and
- Transportation of individuals.

The following additional factors may influence the standard methodology and are the basis for rate variations. When all factors are equal, the rates produced by the standard methodology would be the same.

- Provider rates may vary due to geographic differences.
- A differential may be included in the rate for the level of expertise and skill of specific professional staff; the differential will again be uniform across all providers.

Once the rates are established, rates may be adjusted through contractual amendments subject to cost of living increases appropriated by the Illinois General Assembly, through negotiations during contract renewals, or through subsequent calls for Request for Applications.

Established rates are published on the Operating Agency's website at: <http://www.dhs.state.il.us/page.aspx?item=38992>. The rates published for 24-Hour Stabilization services are actual rates for services.

RFAs are posted on a website used by all State agencies to list contracting opportunities with the State. This website is referred to as the Illinois Procurement Bulletin (IPB). Vendors of all types can register on the IPB to do business with the state, to review requests for information or proposals, and receive updates on procurement rules and requirements. The RFA for this service used the IPB website. We believe this process is an effective means to identify all qualified and willing providers and to compare their costs.

The State anticipates there may be geographic differences in the wages of direct support staff, as well as those of professional staff. We believe there may also be geographic differences in the pricing of clinical contracts such as those with behavior therapists, nurses, etc. There may also be differences in administrative components, employment related costs, and transportation expenses. We also anticipate differences in room and board components; however, those components will not be included in the claiming rate submitted for Medicaid match. We anticipate one vendor will be operating in the Cook County area near Chicago; the other vendor would be operating in Central Illinois in a relatively more rural area.

The Illinois General Assembly reviews funding allocations on an annual basis. We cannot predict, however, how frequently the Administration and General Assembly may consider COLAs for various services.

Public Act 100-0023 was recently enacted to fund a minimum of a \$0.75 per hour wage increase for front-line personnel, including, but not limited to direct support persons, aides, front-line supervisors, qualified intellectual disabilities professionals, nurses, and non-administrative support staff working in community-based provider organizations serving individuals with developmental disabilities. The intent of the wage increase is to improve wages and/or benefits for the above referenced categories of employees. The \$0.75 per hour wage increase is intended to benefit all covered employees and to be applied across the board. It is expected that all covered employees will receive the wage and corresponding fringe benefit increase effective August 1, 2017.

The MA retains and exercises final authority over payment rates. It does so in collaboration with the OA, which develops the proposed rates and shares the proposed rates and methodology with HFS for its approval.

General

All rate methodologies are established by the Operating Agency and reviewed and approved by the Medicaid Agency. The Medicaid Agency solicits public comments by means of a public notice when changes in methods and standards for establishing payment rates under the Waiver are proposed. The notice is published in accordance with Federal requirements at 42 CFR 447.205, which prescribes the content and publication criteria for the notice. Whenever rates change, a listing of all covered services and corresponding rates is made available to participants and guardian (when applicable), family members, Information and Assistance in Support of Participant Direction providers, ISC's and providers. Copies of rate methodologies are on file with the Medicaid Agency and the Operating Agency.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Provider Payment

Waiver funding is appropriated to the Operating Agency primarily from the State's General Revenue Fund.

The Operating Agency maintains a computerized payment system that includes authorization for each participant, payments to providers, units of service delivered to each participant, and payment and claiming rates per unit of service.

The payment system contains edits to ensure that payments are made only to providers that are properly enrolled for the services delivered and that payment is made at the correct payment rate. There is a three-party Medicaid Waiver provider agreement (HFS 1413A,R-2-01) between the provider, the Operating Agency and the Medicaid Agency. This agreement contains language that the provider voluntarily reassigns payment to the Operating Agency (OA). If a provider chooses not to assign payment to the Operating Agency, the provider will sign the standard Medicaid provider agreement (HFS-1413).

Payments for some services, such as participant-directed Personal Support services where the participant exercises employer authority, flow through the Financial Management Service (FMS) entity and are paid and transmitted to the Operating Agency (DHS) system for claims processing.

Operating Agency Claims Processing

Information from the Operating Agency computerized payment system feeds into the computerized claiming system that contains edits to ensure that the participant has been determined to meet the ICF/IID level of care prior to the date of service. The Operating Agency claiming system picks up the established claiming rate and compares it with the actual payment rate; the lower of the two is the amount claimed. Finally, the Operating Agency claiming system subtracts from the Waiver claim the spenddown obligation of each participant, if any (available on a monthly extract from the Medicaid Agency MMIS system).

Medicaid Agency Claims Processing

The Operating Agency Waiver claiming data are transmitted to the Medicaid Agency via a weekly computer tape exchange. The Waiver subsection of the MMIS matches the participant against the recipient eligibility file to ensure Medicaid eligibility on the date of service and matches the provider against the provider enrollment file to ensure that the provider is enrolled as a Waiver provider with the Medicaid Agency. The Waiver subsection includes edits for Waiver claims that conflict with other Waiver and hospital, nursing home, hospice facility, or ICF/IID claims and

rejects Waiver claims that are duplicative or incompatible.

Federal matching funds are deposited into the State's General Revenue Fund. A small portion of the federal matching funds is deposited into a dedicated fund to be used to fund community services for individuals with developmental disabilities.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Provider billings are validated by the Operating Agency (OA) to verify the effective date of each Waiver service authorized in the participants person centered plan and the participant's level of care eligibility. Providers are required to certify billings are true and accurate.

Provider claims are further validated by applying MMIS processing edits and by conducting Operating Agency (DHS) post-payment reviews. See also Appendix I-1 for additional information on post-payment reviews. Through post-payment reviews, the Operating Agency, based on a representative sample of claims, confirms that services were in accordance with the person centered plan.

When inappropriate billings are identified, the OA either ensures the provider voids the billing or the OA voids the

billing itself in the electronic payment system. This initiates a recoupment of overpayments. This action in turn automatically voids the claim for Federal Financial Participation.

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

The OA performs a post payment review, based on a representative sample of waiver claims. The post payment review looks at whether the services were specified in the person centered plan. The OA reviews a representative sample of claims to determine whether the individual was eligible on the date of services. The OA reviews a representative sample of waiver claims to determine whether the rates paid are in accordance with the reimbursement methodology. The OA submits a quarterly report to the MA with their findings and remediation activities. The MA conducts a validation review based on the quarterly reports to verify that the OA followed their post payment review procedures and verifies that appropriate remediation actions were taken.

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

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

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Under an interagency agreement with the Medicaid Agency, the Operating Agency or a Financial Management Service (FMS) entity, as described in Appendix E, makes payments directly to providers of Waiver services. The Operating Agency then sends electronic claims via computer tape based on the paid services to the Medicaid Agency for further adjudication and Federal Waiver reimbursement purposes.

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- No. The State does not make supplemental or enhanced payments for waiver services.**
- Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)**g. Additional Payment Arrangements****i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:***

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

The Operating Agency (OA)

ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- 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 Funds to the OA (DHS). A portion of the funds are deposited into a dedicated fund for services to persons with developmental disabilities. The funds are not transferred.

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.
 Applicable

Check each that applies:

- Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

- None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- The following source(s) are used**
Check each that applies:
- Health care-related taxes or fees**
- Provider-related donations**
- Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The Operating Agency sets individualized rates for a participant in a Residential Habilitation setting based on a rate methodology that is comprised of the following components:

- Room and Board Component - reimburses community providers for keeping a home in normal operation.
- Program Component - reimburses community providers for providing habilitation services and supports, including training, protective oversight, supervision and other assistance to participants with a developmental disability living in a residential setting.
- Transportation Component - reimburses community providers for providing general transportation to and from community locations that are not day program sites or places where Medicaid State Plan services are delivered.
- Administration Component - reimburses community providers for general staff supervision and overhead related to the delivery of residential supports.
- Individual Supports Component - reimburses community providers for supports that are specific to a participant's needs that are not covered elsewhere.

The Operating Agency determines waiver claims for Residential Habilitation services based on the Program, Transportation, Administration and Individual Supports components of the rates. The Room and Board Component is excluded when calculating Waiver claims.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

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

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

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	39951.94	2715.92	42667.86	108247.49	2812.50	111059.99	68392.13

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)
2	42756.84	2793.75	45550.59	111665.09	2703.95	114369.04	68818.45
3	45874.46	2873.81	48748.27	115190.60	2599.59	117790.19	69041.92
4	48460.97	2956.17	51417.14	118827.41	2499.26	121326.67	69909.53
5	52332.64	3040.89	55373.53	122579.05	2402.80	124981.85	69608.32

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	23049	23049	
Year 2	23049	23049	
Year 3	23049	23049	
Year 4	23049	23049	
Year 5	23049	23049	

Appendix J: Cost Neutrality Demonstration

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

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay is estimated based on the actual length of stay for current waiver participants for State Fiscal Years 2018 through 2022.

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.
- Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Estimates are based on the current utilization and costs among adults enrolled in the Adults with Developmental Disabilities Waiver. Factor D is based on analysis of data for FY2011 - FY2015 costs for participants who received waiver services.
 - Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Ancillary service data was pulled for those people with a DD waiver provider for WY'11 - WY'15. Factor D Prime cost per capita is estimated to increase by 1.89% for WY'18 - WY'22. This percentage is based upon the average historical percent change for WY'11 - WY'15 actual ancillary expenditures for Adults with Developmentally Disabled Waiver participants and carried forward to WY'18 - WY'22.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is based on historical ICF/IID data for ICF/IID recipients of all ages for State Fiscal Years 2010 - 2014. Factor G estimated for WY2018 - FY2022 is based on the historical percent changes trended forward for all years. The average historical cost per capita decrease was 2.96%.

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

Factor G' is based on historical Medicaid ancillary services for those individuals in an ICF/IID setting for FY2010 - FY2014. Factor G' estimated for FY2018 to FY2022 is based upon historical percent changes trended forward for all years. The average historical cost per capita decrease was .17%.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services
Adult Day Care
Community Day Services
Residential Habilitation
Occupational Therapy (Extended Medicaid State Plan)
Physical Therapy (Extended Medicaid State Plan)
Speech Therapy (Extended Medicaid State Plan)
Information and Assistance in Support of Participant Direction
24-Hour Stabilization Services
Adaptive Equipment
Behavior Intervention and Treatment
Behavioral Services (Psychotherapy and Counseling)
Emergency Home Response Services (EHRS)
Home Accessibility Modifications
Non-Medical Transportation
Personal Support
Skilled Nursing
Supported Employment - Individual Employment Support
Supported Employment – Small Group Supports
Temporary Assistance
Training and Counseling Services for Unpaid Caregivers
Vehicle Modification

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						79889.16
Adult Day Care	Hour	13	498.00	12.34	79889.16	
Community Day Services Total:						184367884.29
Community Day Services	Hour	19280	878.92	10.88	184367884.29	
Residential Habilitation Total:						528458175.00
Residential Habilitation	Varies	13005	387.00	105.00	528458175.00	
Occupational Therapy (Extended Medicaid State Plan) Total:						103968.00
Occupational Therapy (Extended Medicaid State Plan)	Hour	152	19.00	36.00	103968.00	
Physical Therapy (Extended Medicaid State Plan) Total:						20736.00
Physical Therapy (Extended Medicaid State Plan)	Hour	16	36.00	36.00	20736.00	
Speech Therapy (Extended Medicaid State Plan) Total:						18432.00
Speech Therapy (Extended Medicaid State Plan)	Hour	256	2.00	36.00	18432.00	
Information and Assistance in Support of Participant Direction Total:						16886957.00
Information and Assistance in Support of Participant Direction	Hour	9830	41.00	41.90	16886957.00	
24-Hour Stabilization Services Total:						3726720.00
24-Hour Stabilization Services	Day	64	90.00	647.00	3726720.00	
Adaptive Equipment Total:						18000.00
Adaptive Equipment	Per Item	36	1.00	500.00	18000.00	
Behavior Intervention and Treatment Total:						23439080.70
Behavior Intervention and Treatment	Hour	8213	35.00	81.54	23439080.70	
Behavioral Services (Psychotherapy and Counseling) Total:						1868751.66
Behavioral Services- Psychotherapy-Individual	Hour	2063	14.00	40.02	1155857.64	
					129139.01	
GRAND TOTAL:						920852207.71
Total Estimated Unduplicated Participants:						23049
Factor D (Divide total by number of participants):						39951.94
Average Length of Stay on the Waiver:						347

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Behavioral Services- Counseling-Group	Hour	931	13.00	10.67		
Behavioral Services- Psychotherapy-Group	Hour	1480	20.00	13.34	394864.00	
Behavioral Services- Counseling-Individual	Hour	843	7.00	32.01	188891.01	
Emergency Home Response Services (EHRS) Total:						120.00
Emergency Home Response Services (EHRS)	Per Month (1 X inst)	4	1.00	30.00	120.00	
Home Accessibility Modifications Total:						1638000.00
Home Accessibility Modifications	Per Item	210	1.00	7800.00	1638000.00	
Non-Medical Transportation Total:						95400.00
Non-Medical Transportation	Per Item	150	53.00	12.00	95400.00	
Personal Support Total:						14355298.00
Personal Support	Hour	9668	1042.00	14.25	14355298.00	
Skilled Nursing Total:						20446.92
Skilled Nursing	Hour	68	9.00	33.41	20446.92	
Supported Employment - Individual Employment Support Total:						10653180.99
Supported Employment - Individual Employment Support	Hour	1458	535.29	13.65	10653180.99	
Supported Employment - Small Group Supports Total:						5246925.49
Supported Employment - Small Group Supports	Hour	886	486.21	12.18	5246925.49	
Temporary Assistance Total:						416240.00
Temporary Assistance	Hour	110	344.00	11.00	416240.00	
Training and Counseling Services for Unpaid Caregivers Total:						13002.50
Training Services for Unpaid Caregivers	Per Event	25	1.00	200.00	5000.00	
Counseling Services for Unpaid Caregivers	Hour	25	10.00	32.01	8002.50	
Vehicle Modification Total:						225000.00
Vehicle Modification					225000.00	
GRAND TOTAL:						920852207.71
Total Estimated Unduplicated Participants:						23049
Factor D (Divide total by number of participants):						39951.94
Average Length of Stay on the Waiver:						347

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Per Item	25	1.00	9000.00		
GRAND TOTAL:						920852207.71
Total Estimated Unduplicated Participants:						23049
Factor D (Divide total by number of participants):						39951.94
Average Length of Stay on the Waiver:						347

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
Adult Day Care Total:						79889.16
Adult Day Care	Hour	13	498.00	12.34	79889.16	
Community Day Services Total:						184367884.29
Community Day Services	Hour	19280	878.92	10.88	184367884.29	
Residential Habilitation Total:						562235100.00
Residential Habilitation	Varies	13556	395.00	105.00	562235100.00	
Occupational Therapy (Extended Medicaid State Plan) Total:						112464.00
Occupational Therapy (Extended Medicaid State Plan)	Hour	142	22.00	36.00	112464.00	
Physical Therapy (Extended Medicaid State Plan) Total:						22464.00
Physical Therapy (Extended Medicaid State Plan)	Hour	13	48.00	36.00	22464.00	
Speech Therapy (Extended Medicaid State Plan) Total:						19440.00
Speech Therapy (Extended Medicaid State Plan)	Hour	270	2.00	36.00	19440.00	
Information and Assistance in Support of Participant Direction Total:						16886957.00
GRAND TOTAL:						985502485.54
Total Estimated Unduplicated Participants:						23049
Factor D (Divide total by number of participants):						42756.84
Average Length of Stay on the Waiver:						349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Information and Assistance in Support of Participant Direction	Hour	9830	41.00	41.90	16886957.00	
24-Hour Stabilization Services Total:						3726720.00
24-Hour Stabilization Services	Day	64	90.00	647.00	3726720.00	
Adaptive Equipment Total:						24500.00
Adaptive Equipment	Per Item	49	1.00	500.00	24500.00	
Behavior Intervention and Treatment Total:						29072108.52
Behavior Intervention and Treatment	Hour	9142	39.00	81.54	29072108.52	
Behavioral Services (Psychotherapy and Counseling) Total:						2158895.62
Behavioral Services-Psychotherapy-Individual	Hour	2308	14.00	40.02	1293126.24	
Behavioral Services-Counseling-Group	Hour	1087	14.00	10.67	162376.06	
Behavioral Services-Psychotherapy-Group	Hour	1783	21.00	13.34	499489.62	
Behavioral Services-Counseling-Individual	Hour	910	7.00	32.01	203903.70	
Emergency Home Response Services (EHRS) Total:						150.00
Emergency Home Response Services (EHRS)	Per Month (1 X inst)	5	1.00	30.00	150.00	
Home Accessibility Modifications Total:						2067000.00
Home Accessibility Modifications	Per Item	265	1.00	7800.00	2067000.00	
Non-Medical Transportation Total:						95400.00
Non-Medical Transportation	Per Item	150	53.00	12.00	95400.00	
Personal Support Total:						167819400.00
Personal Support	Hour	11216	1050.00	14.25	167819400.00	
Skilled Nursing Total:						33977.97
Skilled Nursing	Hour	113	9.00	33.41	33977.97	
Supported Employment - Individual Employment Support Total:						10653180.99
					10653180.99	
GRAND TOTAL:						985502485.54
Total Estimated Unduplicated Participants:						23049
Factor D (Divide total by number of participants):						42756.84
Average Length of Stay on the Waiver:						349

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Individual Employment Support	Hour	1458	535.29	13.65		
Supported Employment – Small Group Supports Total:						5246925.49
Supported Employment – Small Group Supports	Hour	886	486.21	12.18	5246925.49	
Temporary Assistance Total:						642026.00
Temporary Assistance	Hour	154	379.00	11.00	642026.00	
Training and Counseling Services for Unpaid Caregivers Total:						13002.50
Training Services for Unpaid Caregivers	Per Event	25	1.00	200.00	5000.00	
Counseling Services for Unpaid Caregivers	Per Event	25	10.00	32.01	8002.50	
Vehicle Modification Total:						225000.00
Vehicle Modification	Per Item	25	1.00	9000.00	225000.00	
GRAND TOTAL:						985502485.54
Total Estimated Unduplicated Participants:						23049
Factor D (Divide total by number of participants):						42756.84
Average Length of Stay on the Waiver:						349

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						79889.16
Adult Day Care	Hour	13	498.00	12.34	79889.16	
Community Day Services Total:						184367884.29
Community Day Services	Hour	19280	878.92	10.88	184367884.29	
GRAND TOTAL:						1057360388.32
Total Estimated Unduplicated Participants:						23049
Factor D (Divide total by number of participants):						45874.46
Average Length of Stay on the Waiver:						350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Habilitation Total:						597868635.00
Residential Habilitation	varies	14129	403.00	105.00	597868635.00	
Occupational Therapy (Extended Medicaid State Plan) Total:						129276.00
Occupational Therapy (Extended Medicaid State Plan)	Hour	133	27.00	36.00	129276.00	
Physical Therapy (Extended Medicaid State Plan) Total:						23040.00
Physical Therapy (Extended Medicaid State Plan)	Hour	10	64.00	36.00	23040.00	
Speech Therapy (Extended Medicaid State Plan) Total:						20592.00
Speech Therapy (Extended Medicaid State Plan)	Hour	286	2.00	36.00	20592.00	
Information and Assistance in Support of Participant Direction Total:						16886957.00
Information and Assistance in Support of Participant Direction	Hour	9830	41.00	41.90	16886957.00	
24-Hour Stabilization Services Total:						3726720.00
24-Hour Stabilization Services	Day	64	90.00	647.00	3726720.00	
Adaptive Equipment Total:						33500.00
Adaptive Equipment	Per Item	67	1.00	500.00	33500.00	
Behavior Intervention and Treatment Total:						35679294.72
Behavior Intervention and Treatment	Hour	10176	43.00	81.54	35679294.72	
Behavioral Services (Psychotherapy and Counseling) Total:						2489252.53
Behavioral Services- Psychotherapy-Individual	Hour	2586	14.00	40.02	1448884.08	
Behavioral Services- Counseling-Group	Hour	1270	14.00	10.67	189712.60	
Behavioral Services- Psychotherapy-Group	Hour	2148	22.00	13.34	630395.04	
Behavioral Services- Counseling-Individual	Hour	983	7.00	32.01	220260.81	
Emergency Home Response Services (EHRS) Total:						180.00
GRAND TOTAL:						1057360388.32
Total Estimated Unduplicated Participants:						23049
Factor D (Divide total by number of participants):						45874.46
Average Length of Stay on the Waiver:						350

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Home Response Services (EHRS)	Per Month (1 X inst)	6	1.00	30.00	180.00	
Home Accessibility Modifications Total:						2605200.00
Home Accessibility Modifications	Per Item	334	1.00	7800.00	2605200.00	
Non-Medical Transportation Total:						95400.00
Non-Medical Transportation	Per Item	150	53.00	12.00	95400.00	
Personal Support Total:						196175418.00
Personal Support	Hour	13012	1058.00	14.25	196175418.00	
Skilled Nursing Total:						50248.64
Skilled Nursing	Hour	188	8.00	33.41	50248.64	
Supported Employment - Individual Employment Support Total:						10653180.99
Supported Employment - Individual Employment Support	Hour	1458	535.29	13.65	10653180.99	
Supported Employment - Small Group Supports Total:						5246925.49
Supported Employment - Small Group Supports	Hour	886	486.21	12.18	5246925.49	
Temporary Assistance Total:						990792.00
Temporary Assistance	Hour	216	417.00	11.00	990792.00	
Training and Counseling Services for Unpaid Caregivers Total:						13002.50
Training Services for Unpaid Caregivers	Per Event	25	1.00	200.00	5000.00	
Counseling Services for Unpaid Caregivers	Per Event	25	10.00	32.01	8002.50	
Vehicle Modification Total:						225000.00
Vehicle Modification	Per Item	25	1.00	9000.00	225000.00	
GRAND TOTAL:						1057360388.32
Total Estimated Unduplicated Participants:						23049
Factor D (Divide total by number of participants):						45874.46
Average Length of Stay on the Waiver:						350

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						79889.16
Adult Day Care	Hour	13	498.00	12.34	79889.16	
Community Day Services Total:						184367884.29
Community Day Services	Hour	19280	878.92	10.88	184367884.29	
Residential Habilitation Total:						631616580.00
Residential Habilitation	Varies	14636	411.00	105.00	631616580.00	
Occupational Therapy (Extended Medicaid State Plan) Total:						140544.00
Occupational Therapy (Extended Medicaid State Plan)	Hour	122	32.00	36.00	140544.00	
Physical Therapy (Extended Medicaid State Plan) Total:						18360.00
Physical Therapy (Extended Medicaid State Plan)	Hour	6	85.00	36.00	18360.00	
Speech Therapy (Extended Medicaid State Plan) Total:						21528.00
Speech Therapy (Extended Medicaid State Plan)	Hour	299	2.00	36.00	21528.00	
Information and Assistance in Support of Participant Direction Total:						16886957.00
Information and Assistance in Support of Participant Direction	Hour	9830	41.00	41.90	16886957.00	
24-Hour Stabilization Services Total:						3726720.00
24-Hour Stabilization Services	Day	64	90.00	647.00	3726720.00	
Adaptive Equipment Total:						37000.00
Adaptive Equipment	Per Item	74	1.00	500.00	37000.00	
Behavior Intervention and Treatment Total:						41872583.88
Behavior Intervention and Treatment	Hour				41872583.88	
GRAND TOTAL:						1116976821.74
Total Estimated Unduplicated Participants:						23049
Factor D (Divide total by number of participants):						48460.97
Average Length of Stay on the Waiver:						352

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		10926	47.00	81.54		
Behavioral Services (Psychotherapy and Counseling) Total:						2720341.03
Behavioral Services- Psychotherapy-Individual	Hour	2779	14.00	40.02	1557018.12	
Behavioral Services- Counseling-Group	Hour	1385	14.00	10.67	206891.30	
Behavioral Services- Psychotherapy-Group	Hour	2357	23.00	13.34	723174.74	
Behavioral Services- Counseling-Individual	Hour	1041	7.00	32.01	233256.87	
Emergency Home Response Services (EHRS) Total:						210.00
Emergency Home Response Services (EHRS)	Per Month (1 X inst)	7	1.00	30.00	210.00	
Home Accessibility Modifications Total:						2870400.00
Home Accessibility Modifications	Per Item	368	1.00	7800.00	2870400.00	
Non-Medical Transportation Total:						95400.00
Non-Medical Transportation	Per Item	150	53.00	12.00	95400.00	
Personal Support Total:						215127861.00
Personal Support	Hour	14162	1066.00	14.25	215127861.00	
Skilled Nursing Total:						54792.40
Skilled Nursing	Hour	205	8.00	33.41	54792.40	
Supported Employment - Individual Employment Support Total:						10653180.99
Supported Employment - Individual Employment Support	Hour	1458	535.29	13.65	10653180.99	
Supported Employment – Small Group Supports Total:						5246925.49
Supported Employment – Small Group Supports	Hour	886	486.21	12.18	5246925.49	
Temporary Assistance Total:						1201662.00
Temporary Assistance	Hour	238	459.00	11.00	1201662.00	
Training and Counseling Services for Unpaid Caregivers Total:						13002.50
GRAND TOTAL:						1116976821.74
Total Estimated Unduplicated Participants:						23049
Factor D (Divide total by number of participants):						48460.97
Average Length of Stay on the Waiver:						352

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Training Services for Unpaid Caregivers	Per Event	25	1.00	200.00	5000.00	
Counseling Services for Unpaid Caregivers	Per Event	25	10.00	32.01	8002.50	
Vehicle Modification Total:						225000.00
Vehicle Modification	Per Item	25	1.00	9000.00	225000.00	
GRAND TOTAL:						1116976821.74
Total Estimated Unduplicated Participants:						23049
Factor D (Divide total by number of participants):						48460.97
Average Length of Stay on the Waiver:						352

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:						79889.16
Adult Day Care	Hour	13	498.00	12.34	79889.16	
Community Day Services Total:						184367884.29
Community Day Services	Hour	19280	878.92	10.88	184367884.29	
Residential Habilitation Total:						672745500.00
Residential Habilitation	Varies	15255	420.00	105.00	672745500.00	
Occupational Therapy (Extended Medicaid State Plan) Total:						161460.00
Occupational Therapy (Extended Medicaid State Plan)	Hour	115	39.00	36.00	161460.00	
Physical Therapy (Extended Medicaid State Plan) Total:						20520.00
Physical Therapy (Extended Medicaid State Plan)	Hour	5	114.00	36.00	20520.00	
GRAND TOTAL:						1206215093.18
Total Estimated Unduplicated Participants:						23049
Factor D (Divide total by number of participants):						52332.64
Average Length of Stay on the Waiver:						354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech Therapy (Extended Medicaid State Plan) Total:						
Speech Therapy (Extended Medicaid State Plan)	Hour	316	2.00	36.00	22752.00	
Information and Assistance in Support of Participant Direction Total:						16886957.00
Information and Assistance in Support of Participant Direction	Hour	9830	41.00	41.90	16886957.00	
24-Hour Stabilization Services Total:						3726720.00
24-Hour Stabilization Services	Day	64	90.00	647.00	3726720.00	
Adaptive Equipment Total:						50500.00
Adaptive Equipment	Per Item	101	1.00	500.00	50500.00	
Behavior Intervention and Treatment Total:						51567852.96
Behavior Intervention and Treatment	Hour	12162	52.00	81.54	51567852.96	
Behavioral Services (Psychotherapy and Counseling) Total:						3125713.11
Behavioral Services- Psychotherapy-Individual	Hour	3109	14.00	40.02	1741910.52	
Behavioral Services- Counseling-Group	Hour	1617	15.00	10.67	258800.85	
Behavioral Services- Psychotherapy-Group	Hour	2839	24.00	13.34	908934.24	
Behavioral Services- Counseling-Individual	Hour	1125	6.00	32.01	216067.50	
Emergency Home Response Services (EHRS) Total:						240.00
Emergency Home Response Services (EHRS)	Per Month (1 X insti	8	1.00	30.00	240.00	
Home Accessibility Modifications Total:						3619200.00
Home Accessibility Modifications	Per Item	464	1.00	7800.00	3619200.00	
Non-Medical Transportation Total:						95400.00
Non-Medical Transportation	Per Item	150	53.00	12.00	95400.00	
Personal Support Total:						251671743.75
Personal Support	Hour				251671743.75	
GRAND TOTAL:						1206215093.18
Total Estimated Unduplicated Participants:						23049
Factor D (Divide total by number of participants):						52332.64
Average Length of Stay on the Waiver:						354

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		16429	1075.00	14.25		
Skilled Nursing Total:						79281.93
Skilled Nursing	Hour	339	7.00	33.41	79281.93	
Supported Employment - Individual Employment Support Total:						10653180.99
Supported Employment - Individual Employment Support	Hour	1458	535.29	13.65	10653180.99	
Supported Employment – Small Group Supports Total:						5246925.49
Supported Employment – Small Group Supports	Hour	886	486.21	12.18	5246925.49	
Temporary Assistance Total:						1855370.00
Temporary Assistance	Hour	334	505.00	11.00	1855370.00	
Training and Counseling Services for Unpaid Caregivers Total:						13002.50
Training Services for Unpaid Caregivers	Per Event	25	1.00	200.00	5000.00	
Counseling Services for Unpaid Caregivers	Per Event	25	10.00	32.01	8002.50	
Vehicle Modification Total:						225000.00
Vehicle Modification	Per Item	25	1.00	9000.00	225000.00	
GRAND TOTAL:						1206215093.18
Total Estimated Unduplicated Participants:						23049
Factor D (Divide total by number of participants):						52332.64
Average Length of Stay on the Waiver:						354