

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

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

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

1. Request Information

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

B. **Program Title:**

Residential Waiver for Children and Young Adults with Developmental Disabilities

C. **Waiver Number:** IL.0473

Original Base Waiver Number: IL.0473.

D. **Amendment Number:**

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

01/01/27

Approved Effective Date of Waiver being Amended: 07/01/22

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The purpose of this amendment is to:

- 1) Implement a 3% rate increase for Child Group Home in response to DCFS rate increases, effective 1/1/2027, or upon CMS approval.
- 2) Update Appendix I-2-a to reflect the rate increase mentioned above.
- 3) Update Appendix J-2-c-i to reflect the rate increase mentioned above.
- 4) Revise Appendix B-3-f, Selection of Entrants to the Waiver, allowing Child Group Home residents placed by DCFS where parental rights have been fully restored to be the only recognized priority group in the Children's Residential Waiver.
- 5) Revise Performance Measure B2 and B3 to change the sampling approach from 100% review to representative sample with 95% confidence level with a +/-5% margin of error. The data source was also changed to record review.
- 6) Revised Appendix F-3, Grievance/Complaint system, to meet the requirements in the federal HCBS Access Rule.
- 7) Revise Performance Measure I2 to change the responsible party for for data collection/generation from the Operating Agency to Medicaid Agency. The data source was also changed to MMIS.
- 8) No changes were made to update Appendix J-2-d for the rate increases noted above for WY5 since the rate increases were less than 10%, per CMS guidance, and the current waiver projections were sufficient to cover the increases.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A - Waiver Administration and Operation	
☒ Appendix B - Participant Access and Eligibility	B-3-f, Quality Improvement
☐ Appendix C - Participant Services	
☐ Appendix D - Participant Centered Service Planning and Delivery	
☐ Appendix E - Participant Direction of Services	
☒ Appendix F - Participant Rights	F-3

Component of the Approved Waiver	Subsection(s)
☐ Appendix G - Participant Safeguards	
☐ Appendix H	
☒ Appendix I - Financial Accountability	I-2-a, Quality Improvement
☒ Appendix J - Cost-Neutrality Demonstration	J-2-c-i

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

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

Specify:

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

1. Request Information (1 of 3)

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

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

Residential Waiver for Children and Young Adults with Developmental Disabilities

C. Type of Request: amendment

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

☐ 3 years ☒ 5 years

Original Base Waiver Number: IL.0473

Draft ID: IL.022.03.06

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/22

Approved Effective Date of Waiver being Amended: 07/01/22

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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:

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 section 1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under section 1915(b) of the Act.**

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

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

☐ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**

☐ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 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 section 1915(i) of the Act.**

☐ **A program authorized under section 1915(j) of the Act.**

☐ **A program authorized under section 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 Illinois Department of Healthcare and Family Services (HFS), the state Medicaid Agency (MA), has delegated the day-to-day operations for the waiver to the Illinois Department of Human Services (IDHS), Division of Developmental Disabilities (DDD), the Operating Agency (OA). Responsibilities of each agency are defined in an interagency agreement.

The OA is the lead agency for community-based services and supports to Illinois residents who have developmental disabilities. The OA is responsible for eligibility, person-centered plan (PCP) development and implementation, enrolling waiver providers, reporting to the MA, and assuring services and providers meet established standards. The MA enrolls providers in Medicaid, provides oversight, consultation and monitoring, processes federal claims and maintains an appeal process.

The Children's Residential Waiver provides 24-hour residential supports to eligible children and young adults with developmental disabilities from age three through age twenty-one who meet functional and financial eligibility. The supports provided are designed to prevent or delay the need for residential services in an ICF/IID. Children who are wards of the State are not eligible for this program.

Customer need for waiver services is determined by the ISC agencies, which are under contract with the OA. Individual Service and Support Advocacy coordinators (ISSAs) are employed by ISCs.

ISCs practice a person-centered approach to assessment, care planning and on-going care coordination. Customers are provided with the opportunity to lead the person-centered care planning process. Those who choose not to lead are still engaged at all levels of assessment and care planning. ISCs evaluate applicants need for 24-hour residential supports using a standardized needs assessment process. This discovery process is part of a comprehensive care assessment and designed to identify all needs and risks of the customer, including health and well-being, depression, suicide, substance abuse, and support to and from care givers. Customers receiving waiver services are informed of their rights and responsibilities and their role in the PCP of care. Rights and responsibilities are defined in official documents, on the website and reviewed and explained at various points of the assessment and planning processes with signatures and other affirmations documenting participation and acknowledgement. The customer and the provider(s) who is/are responsible for the implementation of the PCP will receive a copy of the PCP. Providers must sign the PCP and return it to the ISC.

The OA certifies provider qualifications during the application process and prior to contracting with providers of waiver services. Providers must meet standards before being certified. ISCs are trained to educate customers on available providers and assist customers in making informed choices. Customers are given the choice of receiving waiver services, and if they chose waiver services, they are given the choice of providers. Customers may receive one service or multiple waiver services. Services available under the waiver include Child Group Home, Assistive Technology, and Adaptive Equipment.

The MA and the OA maintain separate but complementary processes to monitor customer welfare, service access and quality. The OA provides the MA with reports of their monitoring activities, including sanctions for agencies with issues of non-compliance. Negative findings are addressed with corrective actions. The MA and OA meet quarterly to discuss reports that identify problematic trends and track the effects of remediation efforts to improve performance.

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 section 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 section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

- ☐ **Not Applicable**
- ☐ **No**
- ☒ **Yes**

C. Statewide. Indicate whether the state requests a waiver of the statewide requirements in section 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 section 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 inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR Part 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. 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 Part 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:

This amendment does not require public notice.

- 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:

Winsel

First Name:

Pamela

Title:

Senior Public Service Administrator

Agency:

Illinois Department of Healthcare and Family Services

Address:

201 South Grand Avenue East

Address 2:

2nd Floor

City:

Springfield

State:

Illinois

Zip:

62763

Phone:

(217) 782-6359

Ext:



TTY

Fax:

(217) 557-8604

E-mail:

Pamela.Winsel@illinois.gov

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

Last Name:

Cooch

First Name:

Meg

Title:	Senior Public Service Administrator		
Agency:	Department of Human Services, Division of Developmental Disabilities		
Address:	600 East Ash Street		
Address 2:	Building 400, 3rd Floor		
City:	Springfield		
State:	Illinois		
Zip:	62703		
Phone:	(217) 782-5919	Ext:	☐ TTY
Fax:	(217) 782-9444		
E-mail:	Meg.Cooch@illinois.gov		

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

	401 South Clinton		
Address 2:			
City:	Chicago		
State:	Illinois		
Zip:	60607		
Phone:	(312) 515-6768	Ext:	☐ TTY
Fax:	(312) 793-1640		
E-mail:	Laura.Phelan@illinois.gov		
Attachments	Laura.Phelan@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:

There are no changes that could result in reduced services to participants.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

CONTINUED FROM G-2-a-i Safeguards Concerning the Use of Restraints:

Restrictions on other types of Restraint are prohibited as follows:

1. Prone Restraint (i.e. being restrained, face down against the floor or another surface) is prohibited.
2. Supine Restraint (i.e. being restrained, face up) is prohibited.
3. Mechanical Restraint is prohibited. Mechanical Restraint does not include any restraint used to treat a customer's medical needs; protect a customer known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness; provide a supplementary aid or service or an accommodation, including, but not limited to, assistive technology that provides proprioceptive input or aids in self-regulation; or promote customer safety in vehicles used to transport customers.
4. Chemical Restraint is prohibited. Chemical Restraint does not include medication legally prescribed and administered as part of a customer's regular medical regimen including PRN medication, to manage behavioral symptoms and treat medical symptoms.
5. If any of the above types of Restraint is utilized by provider agency staff, the incident must be reported via CIRAS as well as reported to the DCFS as appropriate.

All provider agency employees are required to receive the following:

A) Developmentally appropriate training initially (at hire) and annually thereafter, that shall include, but not be limited to:

1. Crisis de-escalation;
2. Trauma-informed practices;
3. Behavior management practices; and
4. Alternatives to the use of restraint..

B) If the provider agency is utilizing Restraint, the provider agency staff must receive developmentally appropriate training initially (at hire) and annually thereafter, that shall include, but not be limited to:

1. Restraint techniques;
2. Restrictive interventions;
3. Restorative practices; and
4. Identifying signs of distress during restraint.

C) If provider agency staff are involved in Restraint not identified in the PCP, the provider agency may require them to complete remediation training on Restraint.

D) A copy of the provider agency's policies on the use of Restraint. Any customer, guardian, if applicable, organization or advocate may file a signed, written complaint with the Director of the Division of Developmental Disabilities, alleging that the provider agency serving the customer has violated this section.

CONTINUED FROM APPENDIX I-1

The OA also conducts onsite compliance reviews for 100% of contracted entities to ensure compliance with contractual obligations. The audit process is the same for all providers. Compliance reviews are conducted annually for 100% of providers. The review cycle begins the date the provide was certified by the OA. Compliance reviews address the following areas to ensure compliance with applicable administrative code and waiver requirements:

- General organizational and administration information, including liability coverage and policies; facility type; specific settings characteristics of the physical site of service provision; billing and records retention.
- Provider standards, including applicable personnel requirements; training; staffing patterns; and safety protocols.
- Service provision, including development, composition, and implementation of person-centered care plan; assurance of customer rights; medical oversight; on-site & off-site activities; meals & snacks as applicable; program outcomes and reporting requirements.

The provider is notified of audit results by mail. A Corrective Action Plan is required to address all findings of non-compliance. Annually, the OA selects a statistically valid sample (with a 95% confidence level and a +/-5% margin of error) of providers and conducts an unannounced review to ensure the corrective action plan is being followed.

The MA 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 HFS Electronic 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.

The MA has implemented oversight procedures that provide increased assurance that claims are coded and paid in accordance with the reimbursement methodology specified in the waiver. These processes enable staff to monitor the financial aspects of the waiver from a global perspective, rather than review a sample of paid claims. The MA determined that reviewing a sample of paid claims was of limited effectiveness and would not likely disclose problematic billings, patterns and/or trends.

The MA staff utilizes its HFS Electronic Data Warehouse query capability to analyze the entire dataset of paid waiver claims. The MA utilizes an exception report and review format as a component of the agency's financial accountability activity. Claims for waiver services are compared with claims for nursing home, hospitalized, or death dates to look for overlapping dates of service to ensure there is no fraudulent or inappropriate billings. Agency staff have constructed database queries that encompass waiver eligibility, coding and payment criteria. Based on these criteria, twice a year the MA conducts analysis of all paid claims and only the claims that were not paid in accordance with set parameters are identified and extracted. The identified exceptions are printed out with all relevant service data. Current exception reports identify paid claims for waiver services to customers who were in a nursing home or who are deceased. In addition to the exception reviews of waiver claims, MA staff conduct targeted reviews of individual waiver services, utilization of waiver services by individual customers and billing trends and patterns of providers. These reviews are usually conducted on an impromptu basis.

The results of all financial reviews are presented to OA personnel under cover memos with supporting claim detail. The OA advises the MA of corrective actions taken, including adjustments, for all service claims identified by the reviews that were not paid in accordance with defined parameters.

The State was approved for a Good Faith Effort exemption request for the implementation of an open/hybrid model Electronic Visit Verification (EVV) on November 21, 2019. On June 3, 2021, the MA posted a Request for Proposal (RFP) to secure the open/hybrid model Electronic Visit Verification (EVV). The winning bidder has been selected. The state anticipates the EVV system will be operational by the end of calendar year 2022. This system will be used for the personal care services (PCS) and Home Health Care Services (HHCS) as defined in the 21st Century Cures Act. PCS are defined as Activities of Daily Living (ADL), such as movement, bathing, dressing, toileting, transferring, and personal hygiene and Instrumental Activities of Daily Living (IADL), such as meal preparation, money management, shopping, and telephone use. HHCS are defined as personal care services or home health care services requiring an in-home visit by a provider that are provided under a state plan or 1915c waiver. Customers have the choice to continue to use the current EVV system operated by the OA or change to the open/hybrid EVV model system that will be maintained by the MA. To ensure financial integrity and accountability, EVV will allow the state to monitor and reduce in unauthorized services, improve the quality of services to customers, and reduce fraud, waste and abuse.

(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).

The MA and OA are responsible for conducting the financial audit program.

The State has several measures in place to ensure that claims describe services rendered. First, errors in billing may be found by the OA or waiver service provider. Second, the MA's claiming system does not allow the OA to submit a claim for a period in which the customer was not active on Medicaid or was active on another HCBS waiver.

Further, the OA has implemented systematic checks and internal controls in the billing system, to combat errors and fraud, which verify customer identification and service authorization information. The OA reviews the identified errors and send in a corrective billing through the OA system. The OA system adjusts current and previous remittance as applicable. The OA system then adjusts any previous claiming based on updated provider payments or recoupments.

Additionally, the MA's Office of Inspector General (OIG) has jurisdiction to investigate concerns of waste, fraud, and abuse. The OA and the MA OIG work closely together to refer concerns for each entity to investigate. Finally, to ensure billing submissions match services provided, QI reviews are conducted by the OA for each OA contracted provider.

CONTINUED FROM I-2-d Billing Validation Process

Another safeguard for all provider billings is that CRS will reject any billing if the billing was previously submitted, adjudicated and paid. Provider agencies cannot bill over the authorized number of units for a day or month of service nor can a provider or provider agency bill over the annually authorized number of units of any specific service for the customer.

Provider claims are further validated by applying MMIS processing edits and by conducting OA post-payment reviews. See also

Appendix I-1 for additional information on post-payment reviews. Through post-payment reviews, the OA, based on a representative sample of claims, confirms that services were in accordance with the PCP.

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:

The Illinois Department of Human Services (IDHS), Division of Developmental Disabilities (DDD)

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:

Healthcare and Family Services (HFS), as the Medicaid Agency (MA), maintains an interagency agreement with the Illinois Department of Human Services, Division of Developmental Disabilities (IDHS-DDD) as the Operating Agency (OA), which outlines the HCBS waiver responsibilities of both agencies. The interagency agreement is reviewed annually and amended if necessary.

The OA is responsible for determination of customer eligibility, person centered plan (PCP) development, budgeting, enrolling and certifying waiver providers, assuring PCPs are implemented, and that services and providers meet standards established in the approved waiver and governing rules. The MA is responsible for enrolling providers in Medicaid; providing oversight, consultation and monitoring of waiver operations; processing federal claims; and maintaining an appeal process. The MA's Waiver Management Unit reviews and approves all OA rules and policies prior to them being presented to the MA's Medical Policy Review Committee for final review and approval. The OA consults the MA about all changes in payment rate and methodologies. All changes must be approved by the MA prior to implementation.

The OA conducts routine oversight monitoring of the fiscal and program activities to assure that the State meets the federal assurances identified in the waiver. The OA's Bureau of Quality Management (BQM) conducts their program reviews. The OA's monitoring tools are reviewed annually and approved by the MA prior to implementation.

The BQM conducts on-site and record reviews to determine provider compliance with the Residential Waiver for Children and Young Adults with Developmental Disabilities. The OA reviews staff training documents to determine if the agencies have completed required initial training, continued mandated ongoing/annual training and required background checks of staff. The staff training and background checks are completed on randomly selected staff members. The OA conducts onsite or desk reviews of person-centered plans (PCPs) at the ISCs and provider agencies to ensure timeliness and completeness of the PCPs. The provider agency onsite reviews include site environmental observations and agency policy and procedures. Customer satisfaction surveys are requested from all sample customers and/or guardians.

The OA uses the Raosoft sample size calculator to determine the number of record reviews for the OA. The sampling methodology is based on a statistically valid approach that uses a 95% confidence level and a +/-5% margin of error.

The OA selects the customer sample from the total number of customers enrolled in the waiver and are submitting claims for waiver services during a specific period for the BQM to review.

The MA holds quarterly meetings with the OA to review program administration and evaluate system performance. Quarterly meetings also discuss broad topics, onsite reviews, and remediation activities unless circumstances warrant communication prior to these meetings. The agencies also communicate regularly to follow up on issues raised during quarterly meetings. In addition, MA/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.

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 Agencies (ISCs): Care coordination services are performed by ISCs under the Operating Agency (OA). ISCs perform the initial and ongoing waiver eligibility determinations for all waiver customers.

ISC functions include:

- 1) Conduct a comprehensive care assessment of need and eligibility initially and at least annually or as needed based on changes in the customer's financial, support or functional needs.
- 2) Outline available services and choices and provide the customer with information to allow the customer or guardian, if applicable, to make informed choices regarding services and providers.
- 3) Develop and update at least annually a PCP with the customer which best meets the customer's desires and needs, with available services through the waiver or other funding sources. Provide the opportunity to the customer or guardian, if applicable, to lead the planning process.
- 4) Monitor service implementation.
- 5) Maintain customer records.
- 6) Link customers to services and providers of their choice.
- 7) Enroll customers on the PUNS database for DD Medicaid services. Update enrollment information at least annually.
- 8) Advocate for customer's rights. Collaborate with service providers to ensure individual's health, safety, welfare, well-being, and satisfaction with services.
- 9) Assist customers who will be entering services to apply for Medicaid benefits and to maintain Medicaid benefits through the Medical Renewal process.

- **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 Operating Agency (OA) is responsible for oversight of the ISCs.

The MA is responsible for assessing the performance of contracted entities in conducting waiver operational and administrative functions.

In the MA's agreement with the OA, the MA has specified for each waiver performance measure the following: responsibility for data collection; frequency of data collection/generation; sampling approach; responsible party for data aggregation and analysis; frequency of data aggregation and analysis; data source; and remediation. For each performance measure, the data source varies according to the performance measure; for many of the measures, the sources are OA reports and BQM record reviews.

The data source for some measures includes customer/guardian satisfaction surveys. The OA collect this data through a representative sample of records, based on the specific performance measure.

The OA is required to submit quarterly reports, using the format required by the MA, on specific performance measures, which are described in MA's agreement with the OA. For each performance measure, the waiver specifies numerators, denominators, sampling approaches, data sources, etc. The OA presents the results to the MA in quarterly meetings. The waiver provider manual includes sanctions for failure to meet requirements for submissions of quality and performance measures.

As part of the OA's quality oversight and monitoring of the waiver providers, the BQM performs onsite audits of the customer PCs through Record Reviews. Upon completion of record reviews, the BQM provides a summary of findings by measure and a plan and Waiver specific summary report of findings and recommendations as appropriate. The report includes: Summary of non-compliance related to specific performance measures; Overall summary of record review findings; and recommendations for remediation of non-compliance. The agencies are required to provide remediation documentation within 60 days for any finding not addressed and corrected during the review. The OA will notify the agencies of approval of the remediation efforts or provide technical assistance to accomplish acceptable remediation. The OA follows-up with the agencies to ensure remediation occurs within the required time frames.

In addition, MA/OA staff communicates regularly regarding any issues that arise relating to the administration of the waiver. These topics include general waiver administration, quality improvement strategies, HCBS Rule transition, etc.

The MA and OA hold quarterly meetings to discuss broad topics, site reviews and remediation activities unless circumstances warrant communication prior to these meetings. The agencies also communicate regularly to follow up on issues raised during quarterly meetings.

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 following describes the oversight of the Independent Service Coordination Agencies (ISCs).

The annual reviews referenced in this section by the OA are part of continued certification that the ISCs are complying with all administrative rules and policies for the OA's Waiver Program.

The OA's ongoing monitoring includes providing the agencies with the review findings. The agencies are required to provide remediation documentation within 60 days for any finding not addressed and corrected during the review. The OA will notify the agencies of approval of the remediation efforts or provide technical assistance to accomplish acceptable remediation.

Oversight of ISCs:

Annually:

OA staff conduct annual on-site surveys or record reviews that focus on compliance with the requirements of the OA's provider manual, as well as contractual requirements. All assessments and reviews may be done more frequently if needed. The OA may conduct more frequent assessments or reviews based on a variety of reasons that may be the result of customer/family caregiver complaints, billing issues or a complaint, among others. These actions may occur if numerous complaints are received for the same agency.

The survey protocol includes staff qualifications and training, 24-hour accessibility for emergencies, a review of the pre-admission screening process (documentation of required assessments, eligibility determinations, informed choice and selection of services, and conflict of interest), and review of the Individual Service and Support Advocacy process (documentation of required visits, participation in PCP development and approval, and annual re-determinations of eligibility).

Agencies are notified in writing of any deficiencies and are required to complete the Remediation Tracking Spreadsheet and submit a plan of correction to the OA, including timeframes (for all findings that cannot be corrected immediately while the reviewers are on site), if the agency scores less than 90% on their overall performance. OA staff review the plan of correction and, if acceptable, approve it.

Reports are completed and sent to the ISC agencies after the review, generally within 30 days. ISC agencies are prescribed a timeframe for completing corrective actions identified in the review. For issues of health, safety and welfare, the timeframe is generally 30 calendar days (or less depending on the severity); for most corrective actions the timeframe is 60 calendar days. If corrective action is not completed in its entirety, a second review is conducted with further corrective action. The OA may initiate contract action, up to and including termination, for an agency with extensive corrective action expectations or issues that jeopardize health, safety, and welfare of customers.

Summary reports of the reviews are shared with and discussed with the MA at the Quarterly Waiver Management meetings.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation

tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

A1 Number and percent of substantive waiver changes where Public Notice and Tribal Notification were completed in accordance with CMS regulations. N: Number of substantive waiver changes where Public Notice and Tribal Notification were completed in accordance with CMS regulations. D: Total number of substantive waiver changes.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Log of Substantive Changes

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

A2 Number and percent of quarterly Quality Management Committee (QMC) meetings between OA and MA where the OA's quality performance data was reviewed as specified in the waiver. N: Number of quarterly QMC meetings between OA and MA where the OA's quality performance data was reviewed as specified in the waiver. D: Number of QMC meetings where OA quality performance data was reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MA Meeting Log

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

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

A3 Number and percent of active waiver customers compared to the approved waiver capacity. **N:** Number of active waiver customers compared to the approved waiver capacity.
D: Total number of CMS approved waiver slots by waiver year.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

MMIS

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review

☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☒ Other Specify: Semi-Annually	

Data Aggregation and Analysis:

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

Performance Measure:

A4 Number and percent of waiver customers residing in a residential setting who state they are able to participate in meaningful activities that help meet their goals/needs. N: Number of waiver customers residing in a residential setting who state they are able to participate in

meaningful activities that help meet their goals/needs. D: Total number of customers 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>):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

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>):
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

A5 Number and percent of waiver customers/guardians who state they feel supported in making decisions to remain independent to the greatest extent possible. N: Number of waiver customers/guardians who state they feel supported in making decisions to remain independent to the greatest extent possible. D: Total number of customers reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

The MA and OA entered into an interagency agreement that is reviewed and updated on at least an annual basis. The OA submits proposed policy changes to the MA. The MA reviews and approves these changes.

The MA and OA meet on a quarterly basis to review program administration and to evaluate the system performance. The quarterly meeting provides opportunities to discuss trends, issues, and remediation activities.

The OA is responsible for following up on all overdue PCP that are identified during reviews until remediation is complete. The MA works with the OA as needed to ensure required remediations have been completed.

For those functions delegated to the OA, the MA is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by the OA.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In

addition, provide information on the methods used by the state to document these items.

A1: The Operating Agency (OA) submits outstanding substantive changes to the Medicaid Agency (MA) for approval. If remediation is not within 30 days, the OA reviews procedures and submits a plan of correction to the MA. The MA follows-up to completion.

A2: The MA will require completion of overdue reports. The OA will submit a plan of correction within 30 days.

A3: The OA and MA monitor to ensure slots remain below capacity. If slots are getting close or going over capacity, the MA will request a waiver amendment to increase capacity.

A4: The ISC staff will inform the provider of interview responses. The ISC staff will continue to follow-up with the customer to determine satisfaction. If no change, ISC staff will follow-up with the provider until resolution. Initial follow-up will occur within 30 days of the finding.

A5: The ISC staff will inform the provider of interview responses. The ISC staff will continue to follow-up with the customer to determine satisfaction. If no change, ISC staff will follow-up with the provider until resolution. Initial follow-up will occur within 30 days of the finding.

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

If remediation is not within 30 days, the OA reviews procedures and submits a plan of correction to the MA. The MA follows up to completion.

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

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

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

ii. Remediation Data Aggregation

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

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

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

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 Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ Aged or Disabled, or Both - General					
	☐	Aged			☐
	☐	Disabled (Physical)			
	☐	Disabled (Other)			
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☒	Autism	3	21	☐
	☒	Developmental Disability	3	21	☐
	☒	Intellectual Disability	3	21	☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

- b. Additional Criteria.** The state further specifies its target group(s) as follows:

Customers must be assessed as eligible for ICF/IID level of care, must need active treatment, must be in need of Children's Residential Waiver services, must reside within the State of Illinois, and must not be in need of nursing assessment, monitoring, intervention and supervision of their condition or needs on a 24-hour basis. Children who are wards of the State are not eligible.

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

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

Specify:

The Children's Residential Waiver includes children and young adults with developmental disabilities age 3 through the age of 21. Adult Developmental Disabilities Waiver services may start at age 18. This four-year transition period is designed to enable customers in the Children's Residential Waiver to transition easily to other programs including other waivers for adults, as appropriate, or ICF/IID services. We expect most customers will choose to transition as they exit the special education system. The State has designed the Children's Residential Waiver so that, as much as possible, eligibility criteria, service definitions, provider qualifications, case management roles and responsibilities, and service implementation are consistent across DDD Waiver programs.

During the course of Waiver services, each customer is assigned a service coordinator from the ISC agency who serves as an independent advocate, participates in PCP development, and monitors service provision. The service coordinator will assist the customer and family during the transition period. The service coordinator will inform the customer and family about adult service options and ensure necessary eligibility screenings are completed.

Customers aging out of the Children's Residential Waiver are authorized automatic transition to the Adults with Developmental Disabilities Waiver as long as they meet clinical and medical eligibility requirements. If a customer is ineligible for the Adult Waiver, assistance is provided to access non-waiver services, State Plan services, or other waiver services as appropriate. ISC entities provide assistance and planning for transition.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

- ☐ **Other**

Specify:

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

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

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

- **The following dollar amount:**

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

- **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**
- **The following percentage that is less than 100% of the institutional average:**

Specify percent:

- **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

can be assured within the cost limit:

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

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

- ☐ **Other safeguard(s)**
- Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	295
Year 2	295
Year 3	295
Year 4	295
Year 5	295

- b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: (*select one*) :
- ☒ The state does not limit the number of participants that it serves at any point in time during a waiver year.

☐ The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

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

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The state (*select one*):

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

Appendix B: Participant Access and Eligibility

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

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- ☒ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ☐ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

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

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

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

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

Entry to the Waiver is offered only to customers who are determined to be in a crisis situation. The State's guidance for determining the existence of a crisis situation is made public on the OA's website at <https://www.dhs.state.il.us/page.aspx?item=85188>. The initial recommendation for a crisis authorization is made by one of the ISC agencies under contract with the OA -the same entities that conduct PUNS assessments and enrollments. Each recommendation is reviewed by the OA.

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

Amendment IL.0473.R03.04, effective 1/1/2027 or upon CMS approval:

Entry into the Children's Residential Waiver is via crisis criteria and priority entry groups only. The only recognized priority group in the Children's Residential Waiver is existing Child Group Home residents placed by DCFS where parental rights have been fully restored. The individual must still meet clinical and Medicaid eligibility for waiver services and be assessed by DDD's clinical and community support teams that they cannot return home to a less restrictive setting with supports.

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*):

- ☐ Section 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)

- ☐ Parents and Other Caretaker Relatives (42 CFR § 435.110)
- ☐ Pregnant Women (42 CFR § 435.116)
- ☐ Infants and Children under Age 19 (42 CFR § 435.118)
- ☐ 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 section 1902(a)(10)(A)(ii)(XIII) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 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:

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

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

- 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 spend down 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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), 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 section 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 section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

- **Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 period after September 30, 2027 (or other date as required by law).

- b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).**

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 period after September 30, 2027 (or other date as required by law).

- c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).**

The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR § 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in section 1924 of the Act. 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
- ☐ The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

Specify the amount of the allowance (select one):

- ☐ 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 § 435.735:

- 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 period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 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).

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 or 42 CFR § 435.735:

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-5-a indicate the selections in B-5-c also apply to B-5-f.

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR § 441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The state requires (select one):

- ☒ **The provision of waiver services at least monthly**
- ☐ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (select one):

- ☐ **Directly by the Medicaid agency**
- ☐ **By the operating agency specified in Appendix A**
- ☐ **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ☒ **Other**
Specify:

Level of care evaluations and reevaluations are performed by local ISC entities under contract with the OA. Issues, findings and status of remediation will be shared with the MA on a quarterly basis.

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

Persons making the initial evaluations must be Qualified Intellectual Disabilities Professionals (QIDPs) as defined in Per 42 CFR §441.303(c)(1). The ISC agencies employ the QIDPs.

Per contractual agreement with the OA, the ISCs are prohibited from providing direct service to waiver customers.

- 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.

Chapter 200 of the Pre-Admission Screening (PAS) Manual describes the required assessments and qualifications for professionals conducting the assessments. For those seeking eligibility, appropriate assessments and evaluations by qualified professionals are required.

The ISC agency determines whether the individual has a developmental disability and, if so, to determine whether the individual needs 24-hour nursing care and/or is eligible for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). These determinations enable the ISC agency to identify and link the individual to needed services.

For all applicants regardless of diagnosis, an Inventory of Client and Agency Planning (ICAP) is required. The ICAP is a Medical review consisting of a physical examination by a qualified professional, medical history and medication review, and other assessments as needed to determine service needs required. 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.

Illinois uses the same process for determining Waiver eligibility as it does for ICF/IID eligibility. 59 Ill. Adm. Code 120.140 requires that prior to Medicaid waiver enrollment, the Preadmission Screening and Resident Review (PASRR) agent shall assess the individual using the same level of care criteria as used for placement into a State-Operated Developmental Center or community ICF/IID. Program services are an alternative to ICF/IID placement. The criteria for this determination are contained in HFS's rule at 89 Ill. Adm. Code 140.642. Individuals demonstrating the ability to function independently shall not be eligible for program services.

For ongoing re-determination of Waiver level of care, a current ICAP is required. An evaluation and periodic (at least annual) reevaluations of the individual's need for the level of care provided in an ICF/IID, as defined by 42 CFR 440.150 (1996) is required in 59 Ill. Adm. Code 120.80.

The Medicaid Agency (MA) will provide oversight to the OA on the monitoring of redeterminations of the Level of Care. The OA conducts quarterly and annual reviews of the redetermination process for all of the ISC agencies. The OA provides this data on their website for public transparency. The link to the OA's website is located at: <http://www.dhs.state.il.us/page.aspx?item=97777>.

The OA contacts the ISC agencies that have redeterminations more than 30 days overdue to request all outstanding redeterminations be completed as soon as possible. OA staff follow up on all overdue redeterminations until the customers shown as overdue are current on their annual waiver eligibility. The MA reviews this data with the OA at quarterly quality management meetings. If trends are identified that reveal noncompliance, an action plan is developed to ensure compliance is achieved. In addition to the OA assessment review and MA oversight, the OA reviews a sample of records to ensure compliance. These reports are shared with the Waiver Operations Management team. If noncompliance is identified, an action plan is 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 (OA) contracts with Independent Service Coordination (ISC) entities that employ Qualified Intellectual Disabilities Professionals (QIDPs) to complete the level of care evaluations and reevaluations.

Administrative Rule 59 Ill. Adm. Code 120.140 requires that prior to Medicaid waiver enrollment, the PASRR agent shall assess the individual using the same level of care criteria as used for placement into a State-Operated Developmental Center or community ICF/IID. Program services are an alternative to ICF/IID placement. The criteria for this determination is contained in HFS's rule at 89 Ill. Adm. Code 140.642. Individuals demonstrating the ability to function independently shall not be eligible for program services.

An evaluation and periodic (at least annual) reevaluation of the customer's need for the level of care provided in an ICF/IID, as defined by 42 CFR 440.150 (1996), is required in 59 Ill. Adm. Code 120.80.

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. The ISC reviews the assessment results and other available information against the level of care criteria and guidance in the screening manual for developmental disabilities. The ISC uses the totality of the information available and their best clinical judgment in making the determination of eligibility. Assessment information and level of care determinations are documented on forms specified by the OA. Level of care determinations are transmitted electronically to the OA via the Reporting of Community Services (ROCS) system.

The redetermination process is essentially the same as the eligibility process, 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 customer. Level of care redeterminations are documented on a form specified by the OA and are transmitted electronically to the OA via the ROCS system.

The OA uses a combination of assessments to determine eligibility, including the ICAP, plus psychological, physical, and psychiatric assessments, as warranted by the customer's related condition(s). ISC's complete an assessment with the customer using a statewide, standardized discovery process developed by the OA with stakeholder input. 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 assessment collects and compiles information about the customer's strengths, needs, preferences, desired outcomes, health, and risk factors. The discovery process guides an interview with the customer. Topics covered include the customer's self-description, communication needs, relationships, living arrangements, work, abilities, health/medication issues, recreation, and community connections. The discovery process is available upon request from the OA.

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

The MA will provide oversight of the OA for monitoring of redeterminations of the Level of Care through two methods.

1. The OA conducts quarterly and annual reviews of the redetermination process. The OA provides this data to the MA, and it is available on the OA website for public transparency. The link to the OA's website is located here: <https://www.dhs.state.il.us/page.aspx?item=31193>. 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 related to a waiver PM, the Remediation Tracking Spreadsheet is completed. If the noncompliance is not related to a PM, a corrective action plan would be developed to address the issue.

- 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*):

ISC staff enter customer demographic and assessment information into a computerized database. This allows ISC staff to track customers and caseloads.

The OA and MA monitor timeliness of reevaluations during monitoring activities.

The OA has an edit in the computerized payment system to ensure re-evaluations are conducted annually. The edit requires the contracted entity to enter the re-evaluation date. If that date is more than one year old, the edit will not allow payments to be made to the entity.

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

Evaluation and reevaluation forms are kept on-site at each Independent Service Coordination (ISC) office under contract with the OA. Files are kept by the ISC 5 years. After five years, the files may be disposed of if the customer is no longer receiving waiver services and all audits have been completed and no litigation is pending or anticipated. If the customer remains enrolled in the waiver, all files will remain in storage either onsite at the ISC office or at a secure location near where the ISC is located.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

B1 Number and percent of applicants for whom there is reasonable indication that services may be needed in the future who received level of care assessment prior to receipt of services. N: Number of applicants for whom there is reasonable indication that services may be needed in the future who received level of care assessment prior to receipt of services. D: Total number of applicants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA Reports: Eligibility Report

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

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

B2 Number and percent of waiver customers reassessed, as specified in the approved

waiver, through the redetermination process of waiver eligibility every 12 months that were reviewed. N: Number of customers who were reassessed, as specified in the approved waiver, through the redetermination process every 12 months. D: Total Number of waiver customers who had reassessment due that were reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☐ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with a +/-5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

B3: # and % of LOC determinations and reevaluations (re-evals) completed for waiver customers using the processes and instruments described in the approved waiver that were reviewed. N: # of LOC determinations and re-evals completed for waiver customers using the processes and instruments described in the approved waiver. D: Total # of LOC determinations and re-evals completed that were reviewed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

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

Agency		
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with a +/-5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	☐ Continuously and Ongoing
	☐ Other Specify:

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

ISCs conduct Level of Care (LOC) determinations. The state ensures LOC determinations are done in an accurate and timely fashion. The state maintains a tracking database in which information about customer LOC determinations is contained. This database contains individual customer level and item level information from the LOC determination tools. Information is collected on a continuous basis. The OA extracts information from these databases regarding the timeliness of the eligibility determinations and redeterminations. The information is summarized in quarterly management reports. The databases also contain edits that ensure that only customers who meet the LOC eligibility threshold are determined eligible for the program. For those functions delegated to the OA such as LOC determinations, the MA is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by the OA. The MA's sampling methodology is based on a statistically valid sampling methodology using a 95% confidence level and a +/-5% margin of error. The MA will pull the sample annually.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

B1:

1. LOC is done/corrected upon discovery
2. If eligible, no additional action
3. If ineligible, correction of billing and claims
4. Individual staff training as appropriate.

Remediation must be completed within 60 days.

B2:

1. LOC is completed upon discovery
2. If eligible, no additional correction required
3. If ineligible, billing and claims adjusted
4. Customer receives assistance with accessing other supports and services.

Remediation must be completed within 60 days.

B3: If it is discovered that the Level II Preadmission Screen (PAS) scores do not support LOC determination; the OA will require a plan of correction from the ISC to include a reassessment or justification if in error. If the justification is inadequate and/or the reassessment does not result in the required scoring, the waiver eligibility will be discontinued, and the OA will assist the customer with accessing other supports and services. Federal claims will be adjusted, and the OA will provide technical assistance or training to Case Managers. Remediation must be completed within 60 days.

The OA is responsible for seeing that individual issues are resolved. The OA provides quarterly reports of these findings and

remediation activities to the MA. Staff of the MA and OA review the reports on a quarterly basis.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

☒ No

☐ Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Customer choice is a requirement of the waiver program as established in 59 Ill. Adm. Code 120.80. The Independent Service Coordination Agencies (ISC) contracted with the Operating Agency (OA) inform customers, and/or their legal guardians, about their options during the level of care determination process. The ISC presents the customer/legal representative with all service options, including both community-based Waiver services and ICF/IID services the customer is eligible to receive, regardless of availability, in sufficient detail so they are able to make informed choices. If the customer/legal representative does not speak English, has limited proficiency or is non-verbal, the ISC makes the appropriate accommodation. Acceptable accommodations may include use of staff with secondary language skills, translation services, oral assistance, and communication devices.

The ISC provides the customer/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. Upon enrollment and annually thereafter each customer is given a statement of rights by the ISC. Selection of providers is discussed in the statement of rights brochure. The statement of rights can be found at: <http://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL462-1201.pdf>. The ISCs are trained to educate customers and provide information to the customer on the available providers, their settings if service is to be delivered outside of the home, and to assist customers, if needed in making an informed choice of providers.

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. This form also states that choice of supports and services may be changed in the future. The form is signed by the customer/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.

Freedom of Choice forms are kept on-site at each Independent Service Coordination (ISC) office under contract with the OA. Files are kept by the ISC 5 years. After five years, the files may be disposed of if the customer is no longer receiving waiver services and all audits have been completed and no litigation is pending or anticipated. If the customer remains enrolled in the waiver, all files will remain in storage either onsite at the ISC office or at a secure location near where the ISC is located.

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 State provides access to waiver services to all eligible customers in Illinois including limited English proficient persons. The local ISC entities under contract with the Operating Agency (OA) serve as access points to the Waiver and are integrated in their communities. Daily the ISC entities interact with a wide variety of customers of varying backgrounds, cultures, and languages. The entities have resources available to communicate effectively with customers of limited English proficiency in their community, including bilingual staff as needed, interpreters, translated forms, etc.

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Child Group Home

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02011 group living, residential habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

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

Residential habilitation also includes personal care and protective oversight and supervision. Payment is not made for the cost of room and board. Payment is not made, directly or indirectly, to members of the customer's immediate family.

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

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

Residential habilitation may be provided in a Child Group Home, a residential setting licensed by the Department of Children and Family Services that serves no more than ten children. It is designed to provide a structured environment and a range of habilitative and therapeutic services to children and adolescents who cannot reside in their own home. Child Group Home services do not include special education and related services (as defined in Section 601 (16) and (17) of the Individuals with Disabilities Education Act) which otherwise are available to the customer through a local education agency.

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

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Child Group Home

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Child Group Home

Provider Category:

Agency

Provider Type:

Child Group Home

Provider Qualifications

License (specify):

89 Ill. Adm. Code 401

89 Ill. Adm. Code 403

Certificate (specify):

Other Standard (specify):

89 Ill. Adm. Code 331 Unusual Incidents

89 Ill. Adm. Code 384 Behavior Treatment in Residential Child Care Facilities

Contract requirements

Verification of Provider Qualifications

Entity Responsible for Verification:

The OA and the Department of Children and Family Services (state licensure agency)

Frequency of Verification:

Annual focused survey and licensure survey every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Service Title:

HCBS Taxonomy:
Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Behavior Intervention and Treatment (BIT) is used when a customer with a developmental disability requires long-term support to improve their daily lives, achieve goals, build skills, or decrease maladaptive behaviors. The use of BIT must be included in the personal plan and must be approved by the customer, family, responsible QIDP, ISC and the other members of the planning team.

BIT includes a variety of individualized, behaviorally based treatment models consistent with best practice and research on effectiveness that are directly related to a customer's therapeutic goals. BIT includes, but is not limited to, Applied Behavior Analysis (ABA), Relationship Development Intervention (RDI), and DIRFloortime® (<https://www.icdl.com/dir>).

The Behavior Support Plan (BSP) should be based on an assessment of the behavior(s) of the customer. Interventions identified must start with the least restrictive measures possible.

- Interventions should be explained to the customers in a way he or she understands.
- There should be clear instructions that use concrete language on how to implement interventions.
- Direct support staff and families of customers receiving BIT must be properly trained on all interventions specified in a BSP. Training must be documented.
- Intervention effectiveness should be determined by reviewing behavior data collection, interviews with staff and unpaid caregivers, and speaking with the customer.
- All restrictive interventions that are implemented at a waiver setting must be reviewed at the Human Rights Committee (HRC) annually.
- The Behavior Management Committee (BMC) should be involved in the development of behavior interventions. The BMC's involvement should be outlined in the HRC manual.

Billable time may be spent completing direct observations and engagement with the customer, as well as indirect services such as, but not limited to, writing the BSP, researching appropriate interventions and training staff.

All providers implementing a BSP must collect data to support the use of any restrictive intervention.

No direct treatment may be delivered during the typical school day relative to the age of the customer or during times when educational services are being provided. Indirect services such as writing recommendations, planning and consultations with school personnel are permitted. Planning for school services and training for school staff may not be included.

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

There is an annual State fiscal year maximum of 66 hours.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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: Extended State Plan 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 (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. Bachelors level professional who is certified as an Associate Behavior Analyst by the Behavior Analyst Certification Board (bacb.com)
4. Professional who is certified to provide Relationship Development Assessment. Information is at rdiconnect.com.
5. Masters level Professional who is certified to provide DIRFloortime®. Information is at icdl.com.
6. Early Intervention Specialist with a Developmental Therapy credential or equivalent experience and training.
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 effectiveness for customers with developmental disabilities.

The Provider must be a Medicaid Enrolled Vendor.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Upon enrollment and annual verification of national certification or 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:

Adaptive Equipment

HCBS Taxonomy:**Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:****Service Definition (Scope):**

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

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

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

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

This service is subject to prior approval by the OA.

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

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

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

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Equipment Vendor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Adaptive Equipment

Provider Category:

Agency

Provider Type:

Equipment Vendor

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Enrolled vendor approved by the OA and customer/family.

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of customers.

Assistive technology service means a service that directly assists a customer in the selection, acquisition, or use of an assistive technology device. Assistive technology includes -

1. The evaluation of the assistive technology needs of a customer, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the customer in the customary environment of the customer;
2. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the customer;
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 PCP.
5. Training or technical assistance for the customer, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the customer; and
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 the customer.

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

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

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

This service is subject to prior approval by the OA.

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

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

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

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed
- ☐ Remote/via Telehealth

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Equipment Vendors

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Equipment Vendors

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Enrolled vendor approved by the OA and customer/family.

Verification of Provider Qualifications

Entity Responsible for Verification:

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 section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☒ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

In addition to residential habilitation, which provides many components of case management services, each customer receives Individual Service and Support Advocacy (ISSA) from independent ISC local entities under contract with the OA. Staff who conduct ISSA functions are Qualified Intellectual Disability Professional (QIDP) staff, and are responsible for the annual re-determinations of level of care, participate in the person-centered planning process, approve all PCPs, advocate on behalf of the customer and family, visit with the customer at least four times per year to update the PCP and ensure health, safety, welfare, and that needs are being met, and shall alert the OA about issues that require additional monitoring and technical assistance.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

Appendix C: Participant Services

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

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

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

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

(a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted:

Criminal background checks with the Illinois State Police are required for ISC staff. 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 for the conviction.

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

(b) the scope of such investigations (e.g., state, national);

The Medicaid Enrollment Agreement signed by the providers includes the requirement for background investigations. The OA annually reviews compliance with this provision through the statistically valid sample of waiver customers by obtaining evidence of the completed investigations by their providers. The results of these reviews are shared with the MA on a summary basis.

The OA conducts a compliance review for each ISC entity to ensure compliance with contractual obligations. After conducting compliance reviews, the OA summarizes information on each performance indicator. The MA and OA review the statewide performance data during quarterly meetings. The summarized data assists the two agencies with identifying potentially problematic trends and tracks the effects of remediation efforts to improve performance. Similarly, detailed reports for each level of entity are shared quarterly. These reports provide the basis for trend identification and specific areas of problems, leading to remediation. When individual problems with existing provider qualifications and contract compliance are identified, there is an initial effort to resolve the situation. When compliance problems occur, the OA makes an initial request for corrective action. This corrective action request is tracked until there is a successful resolution. If there is not successful resolution, the OA may take contract action up to and including contract termination.

The MA and OA meet quarterly to discuss summary reports that include statewide data and corrective action that has been taken by the OA. This provides an opportunity for both agencies to identify trends and issues, and to discuss remediation steps.

(c) the process for ensuring that mandatory investigations have been conducted.

The MA conducts routine programmatic and fiscal monitoring for the OA. The MA is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures.

The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA. The proportionate sampling methodology uses a 95% confidence level and a +/-5% margin of error. The MA will pull the sample annually.

The Medicaid Agency (MA) initiated a provider enrollment system in Fiscal Year 2016 in response to requirements of the Affordable Care Act. The Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system is a web-based system designed to improve provider access, and to ensure customers receive timely and high-quality Medicaid services, including services provided to Medicaid waiver customers. Providers must be enrolled in the IMPACT system prior to being reimbursed for services. Background checks are completed on each provider during the enrollment process. Information about all convictions is shared with the MA's Office of Inspector General (OIG) for review and follow-up. Certain felony convictions will prevent providers from being enrolled in the IMPACT system. The decision to reject an enrollment application on the basis of a felony conviction is determined by the OIG. Providers must meet all qualifications and pass all screening checks to be approved and entered in IMPACT. A provider cannot be enrolled and serve Medicaid customers unless all mandatory screenings have been conducted. Providers must meet all qualifications and pass all screening checks to be approved and entered in IMPACT (HFS

Inspector General's Office, the Illinois Department of Public Health's Health Care Worker Registry, a Healthcare Worker Background Check, the Illinois Department of Professional and Financial Regulation registry, etc.).

The IMPACT system allows the MA to ensure 100% of licensed or certified providers continue to meet the required standards by performing automatic checks of the IL Department of Financial and Professional Regulation's licensure and certification database and exclusion databases. If a provider has a termination or lapse in licensure or certification or appears on an exclusion database, the MA will disenroll the provider and notify the OA. The waiver participant is notified, and a different provider is selected. To ensure an adequate network, both the MA and OA work with providers to correct any lapse in licensure or certification and to troubleshoot any issues with enrollment to regain approved provider status.

Similarly, for non-licensed/non-certified providers, the IMPACT system allows the MA to ensure 100% of providers continue to meet the required standards by performing automatic checks of the IL Department of Public Health's Healthcare Worker Registry and exclusion databases. If a provider has a disqualifying finding on the Healthcare Worker Registry or appears on an exclusion database, the provider is disenrolled and the information is shared with the OA. The waiver participant is notified, and a different provider is selected. To ensure an adequate network, both the MA and OA work with providers to correct any lapse in licensure or certification and to troubleshoot any issues with enrollment to regain approved provider status.

The Illinois Department of Children and Family Services includes verification of staff background checks as a component of the provider qualifications review and approval conducted on an annual basis. A sample of records for each provider is reviewed during this annual approval. Periodically, the OA and MA review providers for compliance with this requirement.

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

- ☐ **No. The state does not conduct abuse registry screening.**
- ☒ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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):

Per the Abused and Neglected Child Reporting Act (325 ILCS 5/1), the Illinois Department of Children and Family Services (DCFS) maintains the State's child abuse and neglect registry. The registry is called the Child Abuse and Neglect Tracking System, or CANTS.

Per the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30), the Illinois Department of Public Health maintains an adult abuse and neglect registry. The registry is called the Healthcare Worker Registry.

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

Abuse/Neglect screenings are required for all Child Group Home employees hired on or after July 1, 2007. ISC staff are also subject to this requirement. Such individuals may not be employed in any capacity until the employer has checked the individual against:

- The Illinois Department of Public Health (IDPH) Health Care Worker Registry, and
- The Illinois Department of Children and Family Services (DCFS) State Central Register (Children's Abuse and Neglect Tracking System - CANTS).

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

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 for compliance with this requirement.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "*extraordinary care*", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

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

- **Other policy.**

Specify:

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

Customers and their legal representatives, with the assistance of the ISC staff, are responsible for selecting needed services and service providers, as part of the person-centered planning process.

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

The OA reviews and approves service providers for participation in the Children's Residential Waiver based on the provider qualifications specified in the Waiver.

The MA enrolls all willing and qualified providers that are chosen by customers in the Children's Residential Waiver and their families.

Information regarding provider qualifications and program guidelines is continuously available on the OA'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.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one:*

- ☒ **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ☐ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
 - ☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
 - ☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
 - ☐ **The HCBS must be identified in the individual's person-centered service plan; and**
 - ☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

And specify: (a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting; (b) How the 1915(c) HCBS will assist the individual in returning to the community; and (c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

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 newly enrolled licensed/certified waiver service providers who meet provider requirements in the approved waiver prior to providing waiver services. N: Number of newly enrolled licensed/certified waiver service providers who meet provider requirements in the approved waiver prior to providing waiver services. D: Total number of newly enrolled licensed/certified providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HFS IMPACT System

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

Specify: 		Describe Group:
	☒ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

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>
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☒ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

C2 Number and percent of enrolled lic/cert waiver service providers who continue to meet provider requirements in the approved waiver prior to continuing to provide waiver services. **N:** Number of enrolled lic/cert waiver service providers who continue to meet provider requirements in the approved waiver prior to continuing to provide waiver services. **D:** Total number of enrolled lic/cert providers

Data Source (Select one):

Other

If 'Other' is selected, specify:

HFS IMPACT System

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
☐ Other Specify: 	☒ Annually
	☒ Continuously and Ongoing
	☐ Other Specify:

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

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

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

Performance Measure:

C3 Number and percent of newly enrolled non-lic/non-cert waiver service providers who meet provider requirements in the approved waiver prior to providing waiver services. N: Number of newly enrolled non-lic/non-cert waiver service providers who meet provider requirements in the approved waiver prior to providing waiver services D: Total number of newly enrolled non-lic/non-cert waiver providers

Data Source (Select one):

Other

If 'Other' is selected, specify:

HFS IMPACT System

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

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

Data Aggregation and Analysis:

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

Performance Measure:

C4: # and % of enrolled non-lic/non-cert waiver service providers who cont. to meet provider reqs in the approved waiver prior to continuing to provide waiver services.

N: # of enrolled non-lic/non-cert waiver service providers who cont. to meet provider reqs in the approved waiver prior to continuing to provide waiver services. D: Total # of enrolled non-lic/non-cert waiver service providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HFS IMPACT System

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

Data Aggregation and Analysis:

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

c. Sub-Assurance: The 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 new ISC staff who receive training in accordance with state requirements and the approved waiver prior to providing waiver services. N: Number of new ISC staff who receive training in accordance with state requirements and the approved waiver prior to providing waiver services. D: Total number of new ISC staff.

Data Source (Select one):

Other

If 'Other' is selected, specify:

ISC Staff Training Reports

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:

C6 Number and percent of ISC staff who receive training in accordance with state requirements and the approved waiver prior to continuing to provide waiver services.

N: Number of ISC staff who receive training in accordance with state requirements and the approved waiver prior to continuing to provide waiver services. **D:** Total number of ISC staff.

Data Source (Select one):

Other

If 'Other' is selected, specify:

ISC Staff Training Reports

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

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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):
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

C7 Number and percent of direct support staff who received training in accordance with state requirements and the approved waiver. N: Number of direct support staff who received training in accordance with state requirements and the approved waiver. D: Total number of direct support staff.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

OA DSP Training Report

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

		Sample Confidence Interval =
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

The Medicaid Agency (MA) will conduct routine programmatic and fiscal monitoring for the Operating Agency (OA). For those functions delegated to the OA, the MA is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by the OA.

The MA has developed queries within the HFS Electronic Data Warehouse to review provider qualifications on a quarterly basis. The MA pulls reports by waiver provider type for both licensed and unlicensed providers to assure that they meet all the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system screening criteria and do not have any Office of Inspector General restrictions including exclusions or sanctions against their licenses. This is done for newly enrolled providers as well as existing providers. The reports will be reviewed and discussed during the quarterly Quality Management meetings.

The IMPACT system allows the MA to ensure 100% of licensed or certified providers continue to meet the required standards by performing automatic checks of the IL Department of Financial and Professional Regulation's licensure and certification database and exclusion databases. If a provider has a termination or lapse in licensure or certification or appears on an exclusion database, the MA will disenroll the provider and notify the OA. The waiver customer is notified, and a different provider is selected. To ensure an adequate network, both the MA and OA work with providers to correct any lapse in licensure or certification and to troubleshoot any issues with enrollment to regain approved provider status.

Similarly, for non-licensed/non-certified providers, the IMPACT system allows the MA to ensure 100% of providers continue to meet the required standards by performing automatic checks of the IL Department of Public Health's Healthcare Worker Registry and exclusion databases. If a provider has a disqualifying finding on the Healthcare Worker Registry or appears on an exclusion database, the provider is disenrolled and the information is shared with the OA. The waiver customer is notified, and a different provider is selected. To ensure an adequate network, both the MA and OA work with providers to correct any lapse in licensure or certification and to troubleshoot any issues with enrollment to regain approved provider status.

For training, the MA will request reports from the OA to verify that ISC staff initially meet, and continue to meet, provider training requirements. These reports will also be shared during the quarterly 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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

C1: If a newly enrolled licensed/certified waiver service provider fails to meet provider requirements, the MA informs the provider of disposition of application and does not enroll into the Medicaid system. OA is also notified of findings.

C2: If an existing licensed/certified waiver service provider fails monthly screening by MA, the MA notifies the provider and OA of the results and disenrolls provider. OA is also notified of findings.

C3: If a newly enrolled non-licensed/non-certified waiver provider fails to meet provider requirements, the MA informs the provider of disposition of application and does not enroll into the Medicaid system. OA is also notified of findings.

C4: If an existing non-licensed/non-certified waiver service provider fails monthly screening by MA, the MA notifies the provider and OA of the results and disenrolls provider. OA is also notified of findings.

C5: If the ISC staff has not met required credentials or completed the required initial training, they are prohibited from performing Case Manager functions until completed. The ISC staff will gain the required credentials and/or complete the required training within 30 days.

C6: If the ISC staff credentials lapse or does not complete the required training, they are prohibited from performing Case Manager functions until completed. The ISC staff will regain credentials and/or complete the required training within 30 days.

C7: The training requirements will be completed. The OA may require a plan of correction from the Direct Support Person (DSP) provider for how training requirements will continually be met for all DSPs. Remediation within 60 days.

For certified ISC staff, the OA will follow-up with a Supervisor.

Outstanding trainings will be completed within 60 days.

The OA is responsible for seeing that these individual issues are resolved. Remediation should be completed within 30 days. The OA provides quarterly reports of the findings and remediation activities to the MA.

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>):
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

☒ No

☐ Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

- ☒ **Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

- **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. *(check each that applies)*

- ☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- ☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- ☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix 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 in which 1915(c) HCBS are received. *(Specify and describe the types of settings in which waiver services are received.)*

Waiver services are rendered in a 24-hour residential setting referred to as a Child Group Home. This includes supported access by the residential provider to the greater community as detailed within the customer's personal plan and as outlined in CFR 441.301(c).

As reflected in the Statewide Transition Plan approved by CMS on February 15, 2023, the OA utilizes non-residential provider settings for the provision of behavior intervention and treatment services. These settings meet the federal HCB settings requirements at 42 §§ CFR 441.301(c)(4)-(5).

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

Initial assessment and ongoing monitoring of federal HCBS setting requirements includes the incorporation of HCBS settings questions into reviews and surveys done by the Bureau of Quality Management (BQM) and the Department of Children and Family Services (DCFS). The person-centered planning process that directs customer's services has been strengthened to include specific questions on HCBS settings compliance based on the customer's perspectives and ongoing experiences receiving services in the community. The OA continues to review and update Illinois rules, policies, procedures, forms, and manuals to also reflect the highest level of commitment to the HCBS Settings Rule.

BQM survey tools have been updated to include HCBS setting questions in July 2023, July 2024, and July 2025. DDD anticipates that all Settings questions will be fully incorporated into survey and review tools by FY27.

Ongoing oversight includes:

- 1) Initially and annually, the OA conducts nursing visits with all residential providers. Nurses make additional onsite visits as needed.
- 2) Initially and annually, DCFS surveys every residential site under the waiver, focusing on compliance with the OA and DCFS rules. Their comprehensive survey tool will include HCBS settings related questions.
- 3) Initially and annually, BQM pulls a random sampling of people receiving services to review their PCP, services, and experiences. 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. BQM's tools are being updated to include HCBS settings questions. BQM reviews all providers at a minimum of every three years.

The OA also contracts with Independent Service Coordination (ISC) agencies who visit each customer a minimum of four times a year to develop a PCP, ensure the plan is being implemented and assure the ongoing health, welfare, and safety of the waiver customers.

3. By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:

- ☒ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**
- ☒ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (see Appendix D-1-d-ii)**
- ☒ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**
- ☒ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**
- ☒ **Facilitates individual choice regarding services and supports, and who provides them.**
- ☒ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an**

intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. (Specify whether the waiver includes provider-owned or controlled settings.)

- ☐ No, the waiver does not include provider-owned or controlled settings.
- ☒ Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, in addition to meeting the above requirements, will meet the following additional conditions):
 - ☒ The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
 - ☒ Each individual has privacy in their sleeping or living unit:
 - ☒ Units have entrance doors lockable by the individual.
 - ☒ Only appropriate staff have keys to unit entrance doors.
 - ☒ Individuals sharing units have a choice of roommates in that setting.
 - ☒ Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
 - ☒ Individuals have the freedom and support to control their own schedules and activities.
 - ☒ Individuals have access to food at any time.
 - ☒ Individuals are able to have visitors of their choosing at any time.
 - ☒ The setting is physically accessible to the individual.
 - ☒ Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan(see Appendix D-1-d-ii of this waiver application).

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. (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 ISC agency staff who provide Individual Service and Support Advocate (ISSA) services are Qualified Intellectual Disabilities Professionals. Per contractual agreement with the OA, the ISCs are prohibited from providing direct service to waiver customers.

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

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.

(a) Supports and information that are made available to the customer:

Upon enrollment, and annually thereafter, each customer/legal representative 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 Rights statement includes information on customer's retention of rights, exercising their rights (and restriction of rights if a guardian has been appointed), non-discrimination, selection of providers, humane care and person centered plans, abuse, neglect and exploitation, coercion, restraints, seclusion, confidentiality, communication rights (mail/phone calls/visits), property rights, money and banking rights, labor rights, right to refuse services, medical and dental services, right to participate in their person centered planning process, voluntary discharge/termination of services, right to file a grievance, right to view their clinical record, and how to report any infringements of their rights, report an Abuse, Neglect or Exploitation allegation or file a complaint/grievance.

The customer/legal representative or other individuals from the customer's support network as the customer/family/guardian chooses, and the ISC work together to develop the person-centered plan (PCP). Effective July 1, 2017 the OA became in full compliance with implementation of federal PCP requirements that encompasses a holistic approach. This included revision of the comprehensive assessment to encourage increased customer/authorized representative involvement in development of the PCP. Significant training was provided to ISC staff on the PCP process and all subsequent new ISC staff training has been updated to ensure the OA is in compliance. Rule(s) are being amended to include the PCP process requirements. OA monitoring tools have been revised to ensure PCP requirements are being included. Direct service providers attend the PCP if the customer or his/her legal representative requests their participation. When not attending meetings, the direct service providers indirectly participate in the PCP process through the use of progress notes and other documentation from current providers to inform planning activities.

As the date and time is set for the PCP and discussion, the ISC is to make every accommodation possible to satisfy and include all persons identified by the customer/legal representative. It is expected that all conversations between the ISC and the customer/legal representative are customer-focused, constantly reinforcing that planning is a collaborative effort, enabling the waiver customer/legal representative to lead the process to the best of his/her abilities and that the outcome of the process is a PCP that is holistic, owned, is agreed to by the customer/legal representative and is reflective of their needs, preferences, person-centered outcomes, safety, welfare, and health status.

The holistic person-centered approach is designed to encompass the comprehensive assessment of the customer's situation and circumstances related to all factors contributing to health, welfare, safety, community integration, quality of life, ability to live independently in the community and the customer's vision for his/her quality of life. ISC staff utilizes the a statewide, standardized Discovery Process for this holistic approach. The use of the discovery process ensures information regarding the customer's goals, needs, and preferences are collected and compiled from various sources such as the ICAP and psychological assessment. 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 assessment collects and compiles information about the customer's strengths, needs, preferences, desired outcomes, health, and risk factors. The discovery process guides an interview with the customer. Topics covered include the customer's self-description, communication needs, relationships, living arrangements, work, abilities, health/medication issues, recreation, and community connections. The discovery process is available upon request from the OA. The plan must then be based on and address the assessed needs, preferences, and desired outcomes. Alternative services may be considered as responsive if the customer and family cannot specifically have what the customer and family prefer due to limitations identified.

ISC staff are trained to discuss potential risks with the customer/legal representative and work together to develop a PCP that will minimize or eliminate risk. All safeguards, supports, education and training necessary to mitigate identified risks are discussed in order to outline additional needed actions to reduce other risks which pose a real or potential threat to the customer's health, safety and/or welfare and will identify who will be responsible for reducing these risks. Once all risks are minimized or eliminated, the customer/legal representative makes decisions to accept any unmitigated risks as part of informed choice.

The ISC provides information and support to enable the customer/legal representative to participate in and direct the planning process. The customer/legal representative 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 by the customer/legal

representative are documented as part of the planning process.

The PCP itself and discussion of the PCP is in plain language and in a manner accessible to the customer/legal representative. The written PCP may be produced in other formats, such as pictures, DVD, etc., to accommodate specific needs of the customer; however, the PCP must exist in a written format as well. The PCP that emerges from this assessment and conversation is one that encompasses all customer needs, desires, outcomes and vision and links the customer with an array of options, not just those programs and services that are components of the waiver. The PCP is the result of this discovery process and it captures the waiver customer's desired outcomes. It identifies supports, both waiver services and non-waiver services, to assist the customer in actualizing these outcomes and desires. The written documentation in the development of the PCP and other assessment forms utilized during the assessment/reassessment processes demonstrate that the waiver customer exercised choice in the decision-making process. Once the PCP is developed by the ISC staff and the customer, it is signed by the customer/legal representative, the ISC staff, and all providers responsible for the PCP's implementation. A copy of the PCP is provided to the customer and all providers listed on the PCP when it is developed and updated.

Annually the customer/legal representative is informed about the process to request updates to the PCP and is informed of his/her right to request a revision to the PCP at any time.

(b) The customer's authority to determine who is included in the process. (OA and ISC Processes):

The Rights Statement outlines the customer's/legal representative rights to attend any meetings about their care. Person-centered planning practices require that the customer be empowered with the ability to determine who they want involved in the planning process. The ISC staff are trained to discuss this with the customers and ensure that their wishes are upheld during all assessments.

42 Code of Federal Regulations (CFR) Part 441.301(c)(1)(i) outlines the customer's right to lead the person-centered planning process where possible. The customer's representative should have a participatory role, as needed and as defined by the customer, unless State law confers decision-making authority to the legal representative. In addition to being led by the customer receiving services and supports, the person-centered planning process includes the customer's right to choose who will participate in the process.

Appendix D: Participant-Centered Planning and Service Delivery

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

- d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. 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):

a) Development of PCP, participation in process, and timing of the plan:

The State is committed to implementation of a person-centered planning (PCP) process as required by 42 CFR 441.301(C)(4)-(5). The ISC staff are trained to include the customer in every aspect of the assessment and PCP development, including providing the customer and his/her representative/guardian with the opportunity to lead the planning process.

The ISC staff contacts the customer or authorized representative, usually by phone, prior to the scheduling of the assessment. Assessments are conducted in a setting that is selected by and most convenient for the customer. The ISC staff schedules the visit around the customer and other parties the customer wishes to have included.

The ISC staff conducts a face-to-face comprehensive ICAP assessment of the customer. 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 diagnoses that includes a primary diagnosis, and recommendations for future service delivery. The physical assessment gathers information on the individual's physical condition. The assessment allows the customer to express his/her goals, which include those related to service needs, overall life goals, and desires and his/her expectations for care. Goals are holistic and are not restricted to only those needs that will be addressed by waiver services.

Customers and anyone they wish to include are encouraged to have an active role in the development of the PCP. This includes choosing services and service providers. The ISC agency completes the PCP with the customer, the customer's family and/or legal guardian, and other individuals from the customer's support network as the customer, family, or guardian chooses. The face-to-face assessment is conducted in a setting that is selected by and most convenient for the customer. The ISC agency may not provide any direct services in order to avoid a conflict of interest.

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

To begin the person center planning process, ISC's complete an assessment with the customer using a standard assessment Discovery Process developed by the Operating Agency (OA) with stakeholder input. The assessment collects and compiles information about the customer's strengths, needs, preferences, desired outcomes, health, and risk factors. The Discovery Process guides an interview with the customer. Topics covered include the customer's self-description, communication needs, relationships, living arrangements, work (career and income), abilities, health/medication issues, recreation, and community connections. The assessment Discovery Process is available upon request from the OA.

The use of the statewide, standardized assessment Discovery Process ensures information regarding the customer's goals, needs, and preferences are collected and compiled. The PCP must then be based on and address the assessed needs, preferences, and desired outcomes. Alternative services may be considered if the customer and family cannot specifically have what the customer and family prefer due to limitations identified.

The Discovery Process is fluid and should be conducted over a period of time, rather than in a single meeting. The completion date of the Discovery Process cannot be more than six (6) months from the date of the upcoming PCP.

The Discovery Process should be updated at least annually but can be updated more often if the customer/guardian request changes. The PCP should be developed only after the Discovery Process (initial or updated) is complete. Prior to the initiation of services or the expiration of the current PCP, the ISC should complete the PCP based on what was learned during the Discovery process, with the exception of crisis cases. For customers considered to be in crisis (homeless, abuse, or neglect), the ISC must complete the Crisis Transition Plan and Funding Request form. The ISC then has 30 calendar days after the date the person begins DD Waiver services to conduct the Discovery Process and develop the PCP.

b) Types of assessments conducted to support the PCP development process, including securing information about customer's needs, preferences and goals, and health status:

In (a) above, the Discovery Process is designed to gather information about a customer's preferences, interests, abilities, preferred environments, activities, identified outcomes, and risk factors and supports needed in the areas of Home, Important Relationships, Career and Income, Health and Well Being, Communication, Life in the Community, Recreation/Interests/Hobbies, Choice and Decision Making, and Future Plans. The ISC can obtain the information in various ways, including via conversations (face to face, phone, e-mails), record reviews, assessments/evaluations, and provider agency notes and summaries. If the individual is currently enrolled in a DD Waiver service, the ISC agency must obtain information from the current provider agency(s).

c) Informing customer of services available under the waiver:

Upon enrollment and at least annually thereafter and during the person-centered planning process, the ISC explains to the customer the array of services, regardless of funding sources, which are available to and for which the customer is eligible. The array of services also includes the customer's goals that may not be met by a waiver or other formal services. It is the ISC staff's responsibility to explain all service options to the customer, including, but not limited to, waiver services. ISC's also explain to the customer the types of services available under the Waiver, as well as all willing and qualified providers of services. The ISC is responsible for informing customers that a listing of all qualified providers by type of provider is available on the OA's website at <https://www.dhs.state.il.us/page.aspx?item=56772>. A written copy of the listing is made available by the ISC upon request by those customers without internet access. The customer is required to sign the PCP to attest that the PCP adequately represents the customer's goals for care and aligns with what the customer wants.

d) Explanation of how the PCP development process ensures the PCP addresses customer goals, needs (including health care needs), and preferences:

The use of the Discovery Process ensures information regarding the customer's outcomes, needs, and preferences are collected and compiled. 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 diagnoses that includes a primary diagnosis, and recommendations for future service delivery. The assessment collects and compiles information about the customer's strengths, needs, preferences, desired outcomes, health, and risk factors. The Discovery Process guides an interview with the customer. Topics covered include the customer's self-description, communication needs, relationships, living arrangements, work, abilities, health/medication issues, recreation, and community connections. The assessment Discovery Process is available upon request from the OA. The PCP must then be based on and address the assessed needs, preferences, and desired outcomes. Alternative services may be considered if the customer and family cannot specifically have what the customer and family prefer due to limitations identified.

e) Explanation of how waiver and other services are coordinated:

The ISC is responsible for implementing the PCP and monitoring its on-going implementation and effectiveness. The ISC is charged with coordinating the various services chosen by the customer, including State Plan services for healthcare and medical needs, as well as generic supports. The ISC is responsible for ensuring that no duplication of services exists. The ISC is responsible for ensuring service providers are identified and linked with the customer for any service identified as needed by the customer, including services beyond those authorized in the Waiver; such as, 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 PCP. The PCP includes all services the customer is receiving, regardless of funding source. The PCP is then sent to each waiver provider listed on the PCP so the providers are aware of additional services or assistance needed or occurring in the residential setting. Providers are trained to report any changes in the customer's situation to the ISC agency.

f) Explanation of how the PCP development process provides for the assignment of responsibilities to implement and monitor the PCP:

The OA mandates that upon the initial assessment, annually, upon request, and when changes in services occur, the ISC must provide the Rights statement to the customer. The OA mandates that this brochure not only be given, but also explained and reviewed with the customer. Documentation in the customer's case record must support that this mandate was met. Provider agencies are also mandated to notify the ISC of changes in the customer's status. OA

policies, rules, and training outline the responsibilities of the ISC staff. These responsibilities include development and continuous monitoring of the PCP.

g) Explanation of how and when the plan is updated, including when the customer's needs change:

The PCP is completed prior to initial service implementation and updated at least annually thereafter. The PCP may be updated more frequently should the customer's needs and circumstances change. The time and location of the assessment and PCP meetings are convenient for the customer and authorized representative.

Administrative rule 59 IL. Adm. Code 120.160 requires that customers receive a new assessment within 365 days after the last eligibility determination or redetermination. A redetermination shall also be conducted if, before 365 days have elapsed, there is a change in circumstances affecting eligibility to ensure continued eligibility.

PCPs are reviewed and adjusted during each assessment. Customers may request a change to the PCP at any time. During assessments, ISC staff educates the customer to call the ISC agency to request a new assessment or to report any changes in his/her living or medical situation that may affect the customer's services.

PCPs can be edited or revised more frequently to meet the customer's changing needs or desires. Whenever there is a significant change in level of service needs or functioning (for example, hospitalization significantly impacting the customer's level of functioning), an assessment edit or revision is to be completed, and additional services provided as needed.

h) how the participant engages in and/or directs the planning process;

The State is committed to implementation of a person-centered planning (PCP) process as required by 42 CFR 441.301(C)(4)-(5). The ISC staff are trained to include the customer in every aspect of the assessment and PCP development, including providing the customer and his/her representative/guardian with the opportunity to lead the planning process.

The person-centered process involves an in-person assessment conducted by the ISC, and an interview of the customer that includes topics relating to self-description, communication needs, relationships, living arrangements, work (career and income), abilities, health/medication issues, recreation, and community connections. The Personal Plan is approved by the customer and his/her representative/guardian prior to distribution and implementation. Customers and anyone they wish to include are encouraged to have an active role in the development of the PCP. This includes choosing services and service providers.

i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative.

Upon completion of the Personal Plan, the ISC will submit a copy of the Personal Plan to the customer and/or guardian (if applicable). The customer and his/her representative/guardian must provide written signature to attest that they approve the Personal Plan as written by the ISC. Upon approval of the Personal Plan by the customer and his/her representative/guardian, the ISC will distribute approved copies of the Personal Plan to the included service providers for review, implementation, and record-keeping. The customer and his/her representative/guardian have the ability to request changes or modifications to the Personal Plan at any time to address the customer's changing needs or desires.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

- ☒ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**
- ☒ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**
 - ☒ **A specific and individualized assessed need for the modification.**
 - ☒ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
 - ☒ **Less intrusive methods of meeting the need that have been tried but did not work.**
 - ☒ **A clear description of the condition that is directly proportionate to the specific assessed need.**

- ☒ Regular collection and review of data to measure the ongoing effectiveness of the modification.
- ☒ Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- ☒ Informed consent of the individual.
- ☒ An assurance that interventions and supports will cause no harm to the individual.

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.

ISC staff assess for customer needs, evaluate current customer risks and work with the customer/guardian to identify the resources and strategies to mitigate these risks through linkage and delivery of services ultimately to prevent institutionalization and be successful in a community setting. As a part of the person-centered planning process, the ISC assesses the customer's associated risk(s). The ISC provides narrative information (including brief overview of current skills as well as potential and known risks) sufficient to guide a provider. Consideration should be given to both the risks associated with current activities of the customer as well as potential risks which inhibit the customer from pursuing his/her goals and fully participating in integrated settings. All safeguards, supports, education and training necessary to mitigate identified risks should be included. The ISC will identify safeguards that are already in place to minimize identified risks and outline additional needed actions to reduce other risks which pose a real or potential threat to the customer's health, safety and/or welfare and will identify who will be responsible for reducing the risks.

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 (PCP), 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 customer and the customer's support network, how the preferences might be limited because of imminent significant danger to the customer's health, safety, or welfare based on the following:

- The customer'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 customer if the customer makes a poor decision;
- The possible long and short-term effects that might result to the customer if the provider limits or prohibits the customer or guardian from making a choice; and
- The safeguards available to protect the customer's safety and rights in each context of choices.

ISC's address risk as part of the discovery process and PCP. Assessments must include the domains listed above and the minimum components described in the discovery process. Assessments must be performed at least annually or more frequently if indicated by the needs of the customer. When conducting risk assessments and making recommendations to mitigate risks, assessors should:

- Gather information from a variety of sources including the individual customer, guardian, family members, provider's commercially or locally developed risk assessment, paid staff, record review, observation, and assessor direct knowledge of the customer.
- Recognize that some domains may not be applicable for all customers. 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 provider agency(ies). Consideration should be given to both the risks associated with current activities of the customer as well as potential risks which inhibit the customer from pursuing his/her goals and fully participating in integrated settings.

Backup plans are developed, if it is determined to be necessary based on risk factors, as part of the PCP development process. If the customer is receiving services from an agency, the agency is required to provide back-up personnel as needed.

This waiver provides support services to children and young adults ages 3 through 21 years, who reside in Child Group Homes. The provider agency is required to provide back-up personnel as needed.

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.

The State requires that freedom of choice be afforded to all customers in the waiver. The OA notifies the ISC of all certified contractual providers that provide services in each geographic area. ISC staff meet with the customers to discuss their outcomes and desires and develop the PCP. It is the ISC's role to provide information about the available service providers to each customer and to answer any questions that arise. A list of providers, by provider type, is available on the Operating Agency (OA)'s website located at <https://www.dhs.state.il.us/page.aspx?item=56772> to assist customers in selecting qualified providers. A written list of providers is available upon request.

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

On an ongoing basis, and at least annually, the ISC assists customers if they want to change providers. At any time, a customer may ask about other providers offering the types of services they are receiving in their geographic area. The PCP is updated when new providers are selected.

The ISC is prohibited from steering a customer toward a provider. The ISC is required to assist in arranging visits to as many providers as a customer chooses. If the customer and guardian requires additional time in order to make a decision, the ISC will periodically inquire regarding whether a decision has been made and whether additional information is needed. The customer must decide which provider they choose.

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):

The Operating Agency (OA) has day-to-day responsibility for completion and approval of PCPs; however, the Medicaid Agency (MA), through its Quality Improvement System, reviews PCPs through a sample process as described below. Annually, OA staff review the adequacy of PCPs through a representative sample during on-site quality assurance reviews. The representative sample is determined using the Raosoft sample size calculator. The sampling methodology is based on a statistically valid approach that uses a 95% confidence level and a +/-5% margin of error. The OA completes a review of the PCPs to assess compliance with the performance measures (PMs) as well as with all applicable state and federal requirements of the representative sample at each ISC annually. Additional reviews are conducted in response to complaints or referrals from other state agencies (DCFS, APS). This ongoing administrative activity allows the OA to ensure the ISCs are adhering to the rules, regulations, policies, and procedures. Prior to the review, the OA checks the Critical Incident Reporting and Analysis System (CIRAS) database to review any complaints/concerns for customers served in the ISC's area. Reports of findings are used to determine recommendations for improvements. Utilizing the Remediation Workbook, the OA provides follow up on all reviews of ISC and provider agencies to ensure corrective actions and remediations have occurred within established timeframes. Reports of findings are shared with the ISC or provider agencies by individual PM, along with recommendations for remediation of findings and/or needed systemic improvement(s). Timeliness of remediation is reported back to the OA based on the requirements of each PM, either immediate, 30, 60, 90 days and any remaining outstanding remediation is continually followed up on by the OA until it is completed. Data from the OA reviews of ISC agencies are aggregated by the OA and shared with the MA staff as part of the Waiver Quality Management quarterly meetings.

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, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ☐ Every three months or more frequently when necessary
- ☐ Every six months or more frequently when necessary
- ☒ Every twelve months or more frequently when necessary
- ☐ Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following (*check each that applies*):

- ☐ Medicaid agency
- ☐ Operating agency
- ☐ Case manager
- ☒ Other

Specify:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a) The entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare:

The State is committed to implementation of a person-centered planning process as required by 42 CFR 441.301(C)(4)-(5). The ISC is responsible for monitoring the implementation of the PCP and the customer's health, safety and welfare. ISC staff and customers develop the PCP together during the initial assessment and at each reassessment the PCP is reviewed and adjusted as needed. Waiver customers are provided with the opportunity to lead the PCP process. The OA administrative rules require that customers receive a new assessment at least annually, when there is significant change, or when the customer requests a new PCP.

The assessment addresses all aspects of customer function and supports. The ISC staff identifies services needed and makes the appropriate referrals, as agreed upon by the customer and the ISC staff during the PCP process. Referrals are made for a variety of services including those outside the services offered in the waiver. The ISC is charged with coordinating the various services chosen by the customer, including State Plan services for healthcare and medical needs, as well as generic supports. The ISC is responsible for ensuring providers are identified and linked for any services identified that the customer 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 minimum frequency of contact for monitoring the PCP's implementation, including direct, in-person contact with the customer, is quarterly. These quarterly monitoring visits are in addition to the direct contact for PCP development. The ISC reviews that the services delivered are in accordance with the PCP and that all services authorized in the PCP are being delivered.

If the ISC determines the PCP is not meeting the customer's assessed needs, the ISC shall work with the customer, family and guardian, if applicable, to ensure the PCP is modified as necessary. If conflicts arise with providers over PCP issues, the ISC must assist the customer in resolving such conflicts. A resolution protocol, including time frames is posted on the OA's website at https://www.dhs.state.il.us/page.aspx?item=115416#a_toc40. The protocol includes a referral to the Operating Agency (OA) for intervention if issues cannot be resolved locally. The OA will collect all available information and work with the parties to bring about a final resolution to the issue. In the event the parties are unable to reach an agreement, the OA will issue a final and binding decision.

Upon enrollment and at least annually thereafter, during the planning process, the ISC explains to the customer what services are available under the Waiver. The ISC is responsible for informing customers that a listing of all qualified providers by type of provider is available on the OAs website located at <https://www.dhs.state.il.us/page.aspx?item=56772>. A written copy of the listing will be provided by the ISC for those customers without internet access upon request.

The ISC is responsible for monitoring the implementation of the PCP and the customer's health, safety, and welfare as required by 42 CFR 441.301(C)(4)-(5).

b) The monitoring and follow up method(s) that are used:

The ISC is responsible for implementing the customer's PCP and monitoring its on-going implementation and effectiveness. ISC staff monitor the provision of services through customer contact, case management services, and satisfaction surveys.

The customer, or their guardian, if applicable, or provider agency can request a follow-up by the ISC. When problems are detected, the PCPs can be revised as needed. Separate from the minimum required monitoring visits and the visit for the Discovery and PCP, the ISC conduct Additional Monitoring visits (face to face) any time there are significant issues or emergencies with the customer receiving waiver services. The number of monitoring visits should be conducted based on the person's needs. Additional Monitoring visits can occur in the customer's residence or in other locations. The location (i.e. Child Group Home, hospital, home) should be based on the situation or reason for monitoring. In most cases, the ISC conduct Additional Monitoring visits within 30 calendar days of becoming aware of an issue. The exact timing of the visit should be based on the urgency of the situation and the potential risks to the customer receiving services.

For overall program monitoring related to PCP development and implementation, the OA monitors the ISC activity

through a representative sample of customers 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. Program monitoring includes the development and implementation of the PCP and ensuring that appropriate follow-up was completed as required. Summary reports are shared with the Medicaid Agency (MA) and discussed during quarterly Quality Management Committee meetings. When problems are identified, they are documented, and remediation efforts are initiated by the OA. Remediation efforts may include revising PCPs, increased monitoring, technical assistance, plans of correction, avoidance of claims, etc.

c) The frequency with which the monitoring is performed:

ISC staff are required to meet face to face with waiver customers four times a year to ensure services are implemented as described in the PCP. Visits will be no more than four months apart and may be more often as needed. Depending on the services a customer receives, an ISC staff person may contact the customer monthly to ask about satisfaction with their services. Separate from the minimum required monitoring visits and the visit for the Discovery and PCP, the ISC conduct Additional Monitoring visits (face to face) any time there are significant issues or emergencies with the customer receiving waiver services. The number of monitoring visits should be conducted based on the customer's needs. Additional Monitoring visits can occur in the customer's residence or in other locations. The location (i.e. Child Group Home, hospital, home) should be based on the situation or reason for monitoring. In most cases, the ISC conduct Additional Monitoring visits within 30 calendar days of becoming aware of an issue. The exact timing of the visit should be based on the urgency of the situation and the potential risks to the customer receiving services.

It is the customer's responsibility to notify ISC staff of any changes in status or to request a change to their PCP. Customers can request a change to the PCP at any time. Provider agencies are required to notify ISC staff of changes in the customer's status. Service provision and customer satisfaction are continually monitored at each assessment. During each reassessment visit, ISC staff reviews the PCP to ensure that services are furnished in accordance with the PCP and the services provided by the service provider are meeting the needs of the customer. A new PCP will be created at each reassessment to capture customer's review and agreement with the PCP even if needs or services have not changed. The need for any additional non-waiver-based services is also discussed.

ISC staff provides on-going education to the customer about reporting any issues with the provision of services and their service providers. The customers are encouraged to call the ISC agency to assist in resolving issues identified by the customer.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ☒ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ☐ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services**

furnished by the entity that is responsible for the person-centered service plan development;

- ☐ An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
- ☐ Direct oversight of the process or periodic evaluation by a state agency;
- ☐ Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
- ☐ Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

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 OA customers' Person Centered Plans (PCPs) that address all personal goals identified by the assessment. N: Number of OA customers' PCPs that address all personal goals identified by the assessment. D: Total number of OA customers' 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):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100%

		Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measure:

D2: Number and percent of OA customers' Person Centered Plans (PCPs) that address all needs identified by the assessment. N: Number of OA customers' PCPs that address all needs identified by the assessment. D: Total number of OA customers' 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):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:

		☐
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

D3: Number and percent of OA customers' Person Centered Plans (PCPs) that address all health and safety risk factors identified by the assessment. N: Number of OA customers' PCPs that address all health and safety risk factors identified by the assessment. D: Total number of OA customers' 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):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review

☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	☐ Continuously and Ongoing
	☐ Other Specify:

- b. Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.**

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 # and % of customers/guardians who were contacted by their ISC staff quarterly in an effort to monitor service provision and to address potential gaps in service delivery. N: # of customers/guardians who were contacted by their ISC staff quarterly in an effort to monitor service provision and to address potential gaps in service delivery. D: Total # of customers/guardians reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		95% confidence level with a +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

- c. **Sub-assurance: 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:

D7: Number and percent of OA waiver customers who have their Person Centered Plan (PCP) updated every 12 months. N: Number of OA waiver customers who have their PCP updated every 12 months. D: Total number of OA waiver customers reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:

		☐
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

D8: Number and percent of OA waiver customers that received updates to their Person Centered Plan (PCP) when there was a change in customer need. N: Number of OA waiver customers that received updates to their PCP when there was a change in customer need. D: Total number of OA waiver customers where a change in customer need was identified that 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):
☒ State Medicaid	☐ Weekly	☐ 100% Review

Agency		
☒ Operating Agency	☒ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ Other Specify: 	☐ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	☐ Continuously and Ongoing
	☐ Other Specify:

d. 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:

D9 Number and percent of customers who received services in the type, scope, amount, duration, and frequency as specified in the PCP. N: Number of customers who received services in the type, scope, amount, duration, and frequency as specified in the PCP. D: Total number of customers reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

		95% confidence level with a +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

- e. **Sub-assurance:** *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:

D10: # and % of OA waiver customers that indicate choice was offered between waiver services and institutional care; and between/among services and providers. N: # of OA waiver customers that indicate choice was offered between waiver services and institutional care; and between/among services and providers. D: Total number of OA waiver customers 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>):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

D1: If PCPs do not address required items, the OA will require the PCPs be corrected and the OA will provide training of ISC Staff. Remediation must be completed within 60 days.

D2: If PCPs do not address required items, the OA will require the PCPs be corrected and OA will provide training of ISC Staff. Remediation must be completed within 60 days.

D3: If PCPs do not address required items, the OA will require the PCPs be corrected and OA will provide training of ISC Staff. Remediation must be completed within 60 days.

D5: OA will require customer be contacted and provide training to ISC staff. Remediation within 60 days.

D7: If PCP is untimely, the OA will require completion of overdue plan and justification from the ISC staff and provide training of ISC staff. Remediation within 60 days.

D8: If plans do not address required items, the OA will require that the plans be corrected and provide training of ISC staff. Remediation must be completed within 60 days.

D9: If a customer does not receive services as specified in the PCP, the OA will determine if a correction or adjustment of the PCP, services authorized, or services vouchered is needed. If not, services will be implemented as authorized. The OA may also provide training to the ISC staff. If the issue appears to be fraudulent, it will be reported by the OA/MA. Remediation must be completed within 60 days.

D10: The OA will assure that choice was provided as shown by the correction of documentation to indicate customer choice. The OA may also provide training to ISC staff. Remediation must be completed within 60 days.

The OA is responsible for seeing that these individual findings are remediated. The OA provides quarterly reports of these activities to the MA. Staff of the two State agencies review the reports on a quarterly basis.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

☒ No

☐ Yes

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

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- ☐ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ☒ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Notification:

Any customer who applies for or receives waiver services has the right to appeal adverse decisions and actions. ISC entities are responsible for informing customers of their right to appeal. The customer is informed by the ISC of his/her right to appeal adverse actions taken regarding services or eligibility. In addition, the customer is informed of their rights at the time of the initial home visit and upon every reassessment. The right to appeal is also covered on the OA's website located at https://www.dhs.state.il.us/page.aspx?item=101181#a_toc8. Customer appeal rights are also outlined in 59 Ill. Adm. Code 120.110.

The OA has developed a standard form, Notice of Individual's Right to Appeal Medicaid Waiver Determinations (IL462-1202, in English and Spanish) for customers to use when filing an appeal. This form is located on the OA's website at <http://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL462-1202.pdf>.

The ISC, OA or provider agency, whichever entity took the adverse decision or action, will notify the customer and/or guardian in writing of the action taken and the process to appeal. The customer and/or guardian will be provided with a notice that includes the action, whether or not services will continue and a copy of the Notice of Individual's Right to Appeal Medicaid Waiver Determinations (IL462-1202). This written notice serves as the notice of the right to appeal for the customer and begins the 10-business day timeframe for the customer to provide written notification to the ISC of their intent to appeal. The customer's services will remain in place at the former levels pending the final decision of the appeal.

OA staff and MA staff are responsible for written notification when there is an adverse decision in the fair hearing process. The OA staff provide written notification during the informal review process. The MA staff provide written notification during the administrative hearing process.

Appeal Process

Customers 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. Adm. Code 104 and 59 Ill. Adm. Code 120.110 describes the fair hearing request procedures in use for the Children's Residential Waiver.

Copies of notices are maintained in the customer's record by the ISC. If customers receive notice of adverse action, they have ten working days to file written notification to the ISC of their intent to appeal. The ISC must submit the appeal packet to the OA within 60 calendar days of the date the customer receives the notice of adverse decision or action. The request for an appeal allows the customer's services to remain in place at the former levels until a final hearing decision is reached or until the appeal is withdrawn.

Once the appeal is filed, the OA has 30 working days to conduct an informal review of the appealed action. The informal review process can reverse, modify, or leave the action unchanged. At the conclusion of the informal review, the customer, and the service provider, if applicable, is notified in writing of the OA's decision within ten working days after the informal review. The written notice includes clear statements of the action to be taken, the reason for the action, supporting policy references, and a complete statement of the customer's right to appeal the decision to the MA. If the customer agrees with the OA's informal review decision, the customer may withdraw their appeal.

If the customer does not agree with the OA's decision through the informal review, the customer has ten working days to appeal the informal review decision and request a formal appeal hearing with the MA for final administrative action. The MA's fair hearings process is the same for all customers. The MA is the final level of Appeal. An MA Hearing Officer conducts the formal hearing. At the hearing, the customer can present evidence on his/her behalf to dispute the adverse action. The customer may choose to be represented by legal counsel or another person the customer appoints. The decision of the formal hearing is made by the Medicaid Director and is final and can only be appealed through the circuit court system.

The MA appoints an impartial hearing officer to conduct the hearing at the MA or OA office nearest to the customer's home unless all parties agree to an alternate location. All parties may participate by phone or video conference.

The Medicaid hearing officer conducts the formal appeal, drafts the decision and sends it to the MA Hearing Supervisor for final review and sign-off by the Medicaid Director. Once a final decision is released by the MA, it is reviewable only through the Circuit Courts of the State of Illinois.

The MA 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**

• **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.

Do not complete this item.

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**
- **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The OA is responsible for the grievance/complaint system.

The ISC entities, under contract with the OA, are responsible for hearing and resolving issues that arise at the local providers. The OA 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 customers. Reports from the database are shared monthly by the OA with the MA. The data is analyzed and evaluated for trends on a quarterly and annual basis. As individual problems and trends are identified, proactive remediation is initiated. The State establishes remediation plans by identifying the responsibilities of the MA and OA and identifying timeframes for completion. The Waiver Quality Management Committee collectively tracks the remediation activity.

- **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).

(a) the types of grievances/complaints that participants may register

Upon enrollment and at each reassessment thereafter, customers and guardians are informed by the ISC of the OA's informal grievance process for making complaints, and that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing. The OA's procedures do not require customers to file an informal grievance prior to exercising their right to appeal. Customers who are dissatisfied with some aspect of service provision may contact the ISC to file grievances or complaints. The ISCs use the Rights of the Individuals form (IL462-1201), found here <https://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL462-1201.pdf>, to document the notification. Options for filing complaints are also posted on the OA's website located at <https://www.dhs.state.il.us/page.aspx?item=52240>.

The type of complaints can include anything of concern to the customer or guardian, e.g., dissatisfaction with the customer's PCP, failure to implement the customer's PCP, quality of services or supports, risk of losing services, etc. In addition, customers can identify and report issues that are program-wide and do not specifically apply to their individual services.

(b) the process and timelines for addressing grievances/complaints

Customers have 30 days to file a complaint/grievance after the incident occurs. When a complaint is received, the OA will make an initial response to the customer making the complaint within two business days to let them know the complaint was received and is being reviewed. The OA has an overall goal to resolve grievances within 30 days. Timeliness is tracked and monitored by the OA and reported and discussed with the MA at the quarterly Waiver Quality Management meetings.

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 customers, 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.

(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

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. Action steps include follow up with the individual submitting the grievance/complaint, waiver customer, provider agency, ISC, etc. to determine cause of the grievance and work with these entities to find a suitable resolution for all parties. 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 shared with the MA at the quarterly Waiver Quality Management meetings. 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 OA has two network-wide reporting structures for tracking and following-up on critical incidents. The first structure covers, all alleged instances of abuse, neglect, self-neglect, or exploitation (ANE) that are reported to the Department of Children and Family Services (DCFS). The second reporting structure is the Critical Incident Reporting and Analysis System (CIRAS).

The Abused and Neglected Child Reporting Act - ANCRA (325 ILCS 5) sets forth the requirements for reporting and responding to situations of ANE against children under the age of 18.

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

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

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

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

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

The types of critical incidents that must be reported include any allegation of physical or mental abuse, neglect or financial exploitation committed by anyone against the Waiver customer. Unauthorized use of restraint, seclusion or restrictive interventions is considered abuse and must be reported. Serious injuries that require treatment by a physician or a nurse where abuse or neglect is suspected and medication errors that have an adverse outcome must be reported.

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 DCFS, known injuries, law enforcement involvement, medical emergencies, missing customers, 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 discovery 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's website located at <https://www.dhs.state.il.us/page.aspx?item=97101>.

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 customer's well-being and ensure any needed actions are taken. The ISC staff review the critical incidents in a timely manner, actively attempt to mitigate risk(s) associated with their occurrence while implementing risk-mitigation strategies aimed at reducing future critical incidents. 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 at the Waiver Quality Management meetings.

ISCs must comply with the 59 Ill. Adm. Code 50, Elder Abuse and Neglect Act, and the Critical Incident reporting requirements of the OA. ISCs must comply with all health, safety, and welfare monitoring and reporting required by State or federal statute or regulation, or that is a condition for a HCBS Waiver, including the following: critical-incident reporting regarding abuse, neglect, self-neglect, and exploitation; critical-incident reporting regarding any incident that has the potential to place a customer, or a customer's services, at risk, but which does not rise to the level of abuse, neglect, or exploitation; and performance measures relating to the areas of health, safety, and welfare and required for operating and maintaining an HCBS Waiver.

Examples of critical events may include but are not limited to:

- 911 Call
- Death
- Unknown Injury
- Law Enforcement
- Medical Emergency
- Missing Individual
- Peer to Peer Acts
- Peer to Staff
- Unauthorized Restraint
- Unknown Injury
- Unscheduled Hospitalization

For these types of incidents, if there is a perceived immediate threat to a customer's life or safety, the ISC and/or provider will follow emergency procedures which may include calling 911.

All incidents will be entered into CIRAS and reported to the OA. Based on the situation, the customer's age or placement reports will also be made to the appropriate State of Illinois investigative agencies.

- 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.

Customers and their families (or guardian, if one has been appointed) are informed by both Child Group Home provider staff and ISC staff about protections from abuse, neglect, and financial exploitation. The information provided includes the process for reporting allegations to the Department of Children and Family Services hotline for customers. Customers and families or guardians are informed that anyone who suspects abuse, neglect or financial exploitation may report an allegation. This information is to be provided to and discussed with customers (or their guardians) by the ISC's at the time of Waiver enrollment and annually thereafter.

Information is provided in the Rights of the Individual form (IL462-1201), located at <https://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL462-1201.pdf>, and is shared with the Customer and guardian (if one has been appointed) upon enrollment and upon every reassessment thereafter. ISC staff discuss the importance of reporting allegations of abuse, neglect and financial exploitation and other critical incidents.

Information on the State's hotline is available on multiple websites and is also listed in the Waiver Manual, located at <https://www.dhs.state.il.us/page.aspx?item=45227>. Instructions about reporting allegations, including the hotline, are also available on the OA website, located at <https://www.dhs.state.il.us/page.aspx?item=52240>.

The OA monitors and ensures customers and guardians have received appropriate information about reporting allegations of abuse, neglect and financial exploitation.

ISC staff receive training on critical incident reporting and follow-up. Direct care staff are provided training through their employer and new state provider standards have enhanced requirements for staff training about abuse, neglect, self-neglect, exploitation, and mandated reporting requirements.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

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

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

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

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

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

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

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

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

The MA and the OA work with the Department of Children and Family Services (DCFS) and share information in order to improve remediation activities with providers serving customers.

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 DCFS, known injuries, law enforcement involvement, medical emergencies, missing customers, 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 electronically to the OA. All reports are accepted. Upon receipt of a report, the ISC agency is automatically notified of the incident. In the case of law enforcement involvement, missing customers, or unscheduled hospitalizations, the ISC agency will work with the reporting provider to take necessary steps to ensure the customer's safety. All CIRAS submissions require a follow-up entry by the ISC within 10 working days of the initial report. 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 OA oversees the reporting and response of all critical incidents and complaints. The OA uses the Critical Incident Reporting and Analysis System (CIRAS) to analyze trends and to ensure that follow up has occurred. For some individual circumstances, the OA may be working with APS or the ISC to resolve the issue. The Department of Children and Family Services (DCFS) maintains a tracking system of ANE investigations and statistical reports are generated annually.

Data is used to inform the OA and MA to monitor system performance and remediate problems.

If a DCFS 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 provider is unable to reach the customer or 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 DCFS as reported by complainants to the DCFS telephone hotline. These reports are received generally within 2 business days of the allegation being reported.

The OA gathers information about the types of allegations and providers to identify patterns and trends.

The OA monitors allegations on an ongoing basis. Summary and analytic reports are developed regarding allegations and findings. These reports are shared with the MA on a quarterly basis during the Quality Management meetings. Summary reports that do not contain confidential information are posted on the OA website.

Both the MA and the OA work together to review performance measures on documentation of the notification to customers of the Rights of the Customer, the reporting of customer 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).

No form of Restraint is permitted except as specified below or as allowed and directed by Administrative Code applicable to the program (e.g. 59 Ill. Adm. Code 120, Medicaid Home and Community-Based Services Waiver Program for Individuals with Developmental Disabilities, 405 ILCS 5, Mental Health and Developmental Disabilities Code, 89 Ill. Adm. Code 401, Licensing Standards for Child Welfare Agencies, 89 Ill. Adm. Code 403, Licensing Standards for Group Homes, 89 Ill. Adm. Code 384, Behavior Treatment in Residential Child Care Facilities, etc.) whichever is more restrictive to the use of Restraint.

Restraint is used only when the customer's behavior presents an immediate threat of serious physical harm to the customer or others and other less restrictive and intrusive measures have been tried and proven ineffective in stopping the immediate threat of serious physical harm. Restraint shall not be used as discipline or punishment, convenience for staff, retaliation, a substitute for appropriate physical or behavioral support, a routine safety matter, or to prevent property damage in the absence of an immediate threat of serious physical harm to the customer or others. The use of Restraint shall be subject to the following requirements and limitations.

A) Restraint may only be employed when:

1. It is included as a modification of rights in a customer's Person-Centered Plan (PCP);
2. The use of Restraint has been discussed and approved for inclusion in the customer's PCP by the customer or guardian, if applicable, and the Provider Support Team;
3. It is included in the customer's behavior plan;
4. The use of Restraint has gone through the Behavioral Management Committee/Human Rights Committee for approval;
5. The inclusion of Restraint in the customer's PCP and behavior plan must include a plan to reduce and ultimately eliminate the use of Restraint, as appropriate;
6. The staff applying the Restraint have been trained in the use of Restraint, as described below, as well as the specific type of the Restraint to be used on the customer;
7. The provider agency has reviewed and determined that there are no known medical or psychological limitations that contraindicate the use of the Restraint;
8. The provider agency has included in the individual rights documentation information for the use of Restraint within the provider agency's policies and procedures and this information has been shared with the customer and guardian, if applicable.

B) Restraint must end immediately when:

1. The immediate threat of serious physical harm ends;
2. The customer indicates that they cannot breathe or staff supervising the customer recognizes they may be in respiratory distress; or
3. The time period of 15 minutes has expired, unless approved in the customer's PCP or a supervisor has approved the instance of the Restraint going beyond 15 minutes.

C) The use of Restraint must be done as follows:

1. Provider agency staff must observe and monitor the customer being physically restrained at all times during the use of Restraint.
2. The staff involved in physically restraining a customer must halt the restraint every 5 minutes to evaluate if the immediate threat of serious physical harm continues to exist. If the immediate threat of serious physical harm continues to exist, staff may continue to use the Restraint and the continued use may not be considered a separate instance of Restraint so long as the total time period of the Restraint does not exceed 15 minutes.
3. A customer shall be released from the Restraint immediately upon a determination by the staff member administering the Restraint that the customer is no longer an immediate threat of causing serious physical harm to themselves or others.
4. The Restraint shall not impair a customer's ability to breathe or communicate normally, obstruct a customer's airway, or interfere with a customer's ability to speak. If the Restraint is imposed upon a customer whose primary mode of communication is sign language or an augmentative mode, the customer shall be permitted to have their hands free of restraint for brief periods, unless the supervising staff determines this freedom appears likely to result in harm to the customer or others.

D) Reporting requirements:

1. In incidents of Restraint, the provider agency shall do the following:

- a. Create a report on the use of Restraint. The Report shall be included in the customer's file and be available for assessment by the Bureau of Quality Management during a provider agency's review.
- b. Review the use of any incident of Restraint via the Human Rights Committee.
2. Any incident of Restraint shall be reported to the provider agency Executive Director/Chief Executive Officer.
3. The provider agency shall notify the customer's guardian, if applicable, no later than 24 hours after any incident of Restraint occurs.

Restraint not identified in the PCP shall be used only when the customer's behavior presents an immediate threat of serious physical harm to the customer or others, the provider agency deems the situation an emergency, and other less restrictive and intrusive interventions have been tried and proven ineffective in stopping the immediate threat of serious physical harm. Restraint not identified in the PCP shall not be used as discipline or punishment, convenience for staff, retaliation, a substitute for appropriate physical or behavioral support, a routine safety matter, or to prevent property damage in the absence of immediate threat of serious physical harm to the customer or others. Restraint not identified in the PCP occurs when the requirements of 1) - 4) above are not in place prior to the use of the restraint. The use of Restraint not identified in the PCP shall be subject to the following requirements and limitations.

A) Restraint not identified in the PCP may only be employed when:

1. The staff applying the Restraint not identified in the PCP have been trained in the use of Restraint;
2. The provider agency has reviewed and determined there are no known medical or psychological limitations that contraindicate the use of the Restraint; and
3. The provider agency has included in the individual rights documentation information on the provider agency's policies and procedures for the use of Restraint and this information has been shared with the customer and guardian, if applicable.

B) Restraint not identified in the PCP must end immediately when:

1. The immediate threat of serious physical harm ends;
2. The customer indicates they cannot breathe or staff supervising the customer recognizes they may be in respiratory distress; or
3. The time period of 15 minutes has expired, unless a supervisor has approved the instance of the Restraint going beyond 15 minutes.

C) The use of Restraint not identified in the PCP must be completed as follows:

1. Provider agency staff must observe and monitor the customer being physically restrained at all times during the use of Restraint.
2. The staff involved in physically restraining a customer must halt the restraint every 5 minutes to evaluate if the immediate threat of serious physical harm continues to exist. If the immediate threat of serious physical harm continues to exist, staff may continue to use the Restraint not identified in the PCP and the continued use may not be considered a separate instance of Restraint not identified in the PCP so long as the total time period of the Restraint not identified in the PCP does not exceed 15 minutes.
3. A customer shall be released from the Restraint not identified in the PCP immediately upon a determination by the staff member administering the Restraint not identified in the PCP that the customer is no longer an immediate threat of causing serious physical harm to themselves or others.
4. The Restraint not identified in the PCP shall not impair a customer's ability to breathe or communicate normally, obstruct a customer's airway, or interfere with a customer's ability to speak. If the Restraint not identified in the PCP is imposed upon a customer whose primary mode of communication is sign language or an augmentative mode, the customer shall be permitted to have their hands free of restraint for brief periods, unless the supervising staff determines this freedom appears likely to result in harm to the customer or others.
5. After Restraint not identified in the PCP has been used, the provider agency shall work with the ISC to determine whether Restraint should be included in the customer's PCP and behavior plan moving forward.

D) Reporting requirements:

1. In incidents of Restraint not identified in the PCP, the provider agency shall do the following:
 - a. Create a report on the use of Restraint not identified in the PCP. The Report shall be included in the customer's file and be available for assessment by the Bureau of Quality Management during a provider

agency's review.

- b. Review any use of Restraint not identified in the PCP via the Human Rights Committee.
2. Any incident of Restraint not identified in the PCP shall be reported to the provider agency Executive Director/Chief Executive Officer.
3. The Director of the Division of Developmental Disabilities or their designee shall receive a report of each incident of Restraint not identified in the PCP via a report from CIRAS.
4. The provider agency shall notify the customer's guardian, if applicable, no later than 24 hours after any incident of Restraint not identified in the PCP occurs.

Restrictions on other types of Restraint are prohibited as follows:

1. Prone Restraint (i.e. being restrained, face down against the floor or another surface) is prohibited.
2. Supine Restraint (i.e. being restrained, face up) is prohibited.
3. Mechanical Restraint is prohibited. Mechanical Restraint does not include any restraint used to treat a customer's medical needs; protect a customer known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness; provide a supplementary aid or service or an accommodation, including, but not limited to, assistive technology that provides proprioceptive input or aids in self-regulation; or promote customer safety in vehicles used to transport customers.
4. Chemical Restraint is prohibited. Chemical Restraint does not include medication legally prescribed and administered as part of a customer's regular medical regimen including PRN medication, to manage behavioral symptoms and treat medical symptoms.
5. If any of the above types of Restraint is utilized by provider agency staff, the incident must be reported via CIRAS as well as reported to the DCFS as appropriate.

All provider agency employees are required to receive the following:

A) Developmentally appropriate training initially (at hire) and annually thereafter, that shall include, but not be limited to:

1. Crisis de-escalation;
2. Trauma-informed practices;
3. Behavior management practices; and
4. Alternatives to the use of restraint.

B) If the provider agency is utilizing Restraint, the provider agency staff must receive developmentally appropriate training initially (at hire) and annually thereafter, that shall include, but not be limited to:

1. Restraint techniques;
2. Restrictive interventions;
3. Restorative practices; and
4. Identifying signs of distress during restraint.

C) If provider agency staff are involved in Restraint not identified in the PCP, the provider agency may require them to complete remediation training on Restraint.

D) A copy of the provider agency's policies on the use of Restraint. Any customer, guardian, if applicable, organization or advocate may file a signed, written complaint with the Director of the Division of Developmental Disabilities, alleging that the provider agency serving the customer has violated this section.

- 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 (OA) is responsible for overseeing the permitted use of Restraint 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 Restraint of customers. The ISC conducts a minimum of four visits per year to develop the PCP and monitor the PCP's implementation, including direct, in-person contact with the customer. 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, including the unauthorized use of Restraint would be reported to the OA, Department of Children and Family Services (DCFS), and/or Adult Protective Services (APS) (if applicable).

Any findings of unauthorized use of Restraint or of injuries to customers 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 Critical Incident Reporting and Analysis System (CIRAS). 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 (DCFS or APS), working with the provider to develop or modify behavior plans and/or any additional action that may be appropriate to the specific circumstances.

If the ISC and provider agency are unable to develop or modify and implement a behavior plan to ensure the unauthorized use of Restraint doesn't happen again, the ISC should refer the matter to the OA using the "Monitoring and Technical Assistance Tool" located here:

<https://www.dhs.state.il.us/page.aspx?item=56646>. The referral must be sent to the OA within two business days. Upon receipt, the referral will be assigned to the appropriate Bureau within the OA for appropriate follow up. The assigned Bureau Chief is responsible for ensuring appropriate and timely follow up. Depending on the nature of the concern being raised by the ISC, the Division may involve additional resources, such as the Support Service Team (SST) and, the Department of Children and Family Services (DCFS).

Provider agencies are required to report the unauthorized use of Restraint, including any instances not in compliance with State regulations, through CIRAS. If a provider agency is submitting a high number of unauthorized use of Restraint reports through CIRAS, the OA could complete an unannounced review of the provider agency to determine what is causing the high volume of unauthorized Restraint. The OA reviews a statistically valid sample (with a 95% confidence level and a +/-5% margin of error) of provider agencies and waiver customers each year to detect the unauthorized use of Restraint, also identifying any service implementation issues such as overuse or inappropriate or ineffective use of Restraint. In completing this review, the OA reviews records; conducts on-site observations; and interviews staff, customers, and guardians.

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 during the quarterly waiver quality management meetings. In addition to ensuring individual issues are resolved, the OA and MA identify system issues and implement enhancements when necessary. If a trend is identified with a provider agency, the provider agency would be required to submit an approved corrective action plan to the OA. The OA may impose sanctions upon the provider agency up to and including termination of the provider agency.

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:

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

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

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

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

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

The rule also prohibits certain actions including, but not limited to, subjecting customers to discipline that is out of proportion to the particular inappropriate behavior or is more than 24 hours after the provider learned of the behavior; subjecting the customer to verbal abuse, threats, or derogatory remarks; using corporal punishment under any circumstances; depriving the customer of food, visits or phone calls with family and professionals, clothing (unless otherwise indicated for clinical or safety reasons), sleep, or exercise; assigning exercise; forcing the customer to take an uncomfortable position; assigning strenuous or harsh work or work that is beyond the capacity of the customer; disciplining for toilet accidents; or depriving the customer of educational services.

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

With respect to acceptable discipline, as described in subsections (e)(1) through (e)(5) of the rule:

Prior to the application of the discipline, the customer shall be informed of the rule infraction;

Prior to application of the discipline, the reasons for the nature of, and duration of the discipline shall be explained to the customer;

The case record shall contain documentation of the discipline applied, specifying the conduct of the customer leading to the discipline and the nature and duration of the discipline; and

The administrator of the facility or designee shall review discipline applied to individual customers within 48 hours after administration of the discipline. The reviewer shall not be the individual who imposed the disciplinary measure. The administrator of the group home or designee shall approve or disapprove of the discipline imposed and shall indicate review and approval/disapproval by signing and dating the report of discipline. If the administrator or designee disapproves of the discipline imposed, the administrator or designee shall state the reasons for disapproval and shall correct the use of improper disciplinary techniques.

The OA reviews these issues during on-site reviews through its statistically valid representative sample of Waiver customers (with a 95% confidence level and a +/-5% margin of error). The MA participates in these reviews as possible. Data, including remediation activity, is collected, aggregated, and analyzed by both the MA and OA under one of the performance measures in Appendix G: The number and percent of substantiated incidents of restrictive interventions, including restraints, reported to the OA where appropriate actions were taken to address the incident.

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

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

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

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

The facility shall report as an unusual incident:

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

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

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

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

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

The Child Welfare Agency licenses the Children's Group Home providers. (See Appendix C.) As part of this licensure activity, it reviews the use of discipline. Copies of the reports of the licensure reviews are shared with the Operating and Medicaid Agencies.

The Operating Agency, using a representative sample of Waiver customers on an annual basis, reviews the use of restrictive interventions through on-site record reviews, interviews, and observations. The on-site reviews include required reporting to the Child Welfare agency and OA. The Medicaid Agency participates in all on-site reviews as possible.

The Operating Agency annually surveys customers families/guardians, using the same representative sample, regarding restrictive intervention issues.

The ISCs, under contract with the Operating Agency, review restrictive intervention issues for every customer during their quarterly monitoring activities. ISC staff are mandated reporters and are thus required to report to the Child Welfare Agency any allegations of abuse or neglect. In addition, they are required through their contracts to report to the Operating Agency any issues with the provider regarding unauthorized use of restrictions.

The Operating Agency uses all of the above sources of information to review reports, ensure remediation is completed, and track trends. Appropriate remediation activity may include corrective action plans, retraining of staff, increased monitoring, systemic procedural modifications, etc. The Operating Agency also aggregates

data and identifies trends from these sources, developing evidentiary reports for review and analysis by the Quality Management Committee during its quarterly meetings. The evidentiary reports summarize remediation timelines as follows: within 30 days, between 31 and 60 days, more than 60 days, and outstanding. The Operating Agency may impose sanctions if necessary to ensure remediation.

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

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 (OA) is responsible for detecting the unauthorized use of seclusion.

The OA contracts with Independent Service Coordination (ISC) agencies to monitor the unauthorized use of seclusion of customers. The ISC conducts a minimum of four visits per year to develop the PCP and monitor the PCP's implementation, including direct, in-person contact with the customer. The ISCs are QIDPs and are subject to mandatory reporting requirements.

The ISCs monitor through on-site observations, interviews, and record reviews. Any potential abuse would be reported to the OA, Department of Children and Family Services (DCFS), and/or Adult Protective Services (APS) (if applicable).

Any findings of the use of Seclusion are required to be reported by the ISC entities to the OA via the OA's Critical Incident Reporting and Analysis System (CIRAS). 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 (DCFS and/or APS), working with the provider to develop or modify behavior plans and/or any additional action that may be appropriate to the specific circumstances.

If the ISC and provider agency are unable to develop or modify and implement a behavior plan to ensure the unauthorized use of Seclusion doesn't happen again, the ISC should refer the matter to the OA using the "Monitoring and Technical Assistance Tool" located here: <https://www.dhs.state.il.us/page.aspx?item=56646>. The referral must be sent to the OA within two business days. Upon receipt, the referral will be assigned to the appropriate Bureau within the OA for appropriate follow up. The assigned Bureau Chief is responsible for ensuring appropriate and timely follow up. Depending on the nature of the concern being raised by the ISC, the OA may involve additional resources, such as the Support Service Team (SST) and the Department of Children and Family Services (DCFS).

Additionally, provider agencies are required to report the unauthorized use of Seclusion through the CIRAS.

The OA tracks and analyzes reports received from ISCs. The OA monitors both the provider and ISC activities through these reports, identifies additional remediation needs, and develops and implements systemic changes when necessary.

The OA reviews a statistically valid sample (with a 95% confidence level and a +/-5% margin of error) of waiver customers each year to detect unauthorized use of seclusion. On-site reviews consist of record reviews, interviews with customers, guardians and staff, and observations. Identification of any unauthorized use of seclusion by a provider is subject to corrective action. The OA may impose sanctions upon the provider agency up to and including termination of the provider agency.

The OA collects data on the reporting of critical incidents, restraint, restrictive interventions, and seclusion as outlined in Appendix G - Performance Measures. The data is summarized and presented at the quarterly Waiver Quality Management meetings. The MA and the OA review summary data and remediation activities and identify 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:

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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*)

- **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 customers and the management of customers' medications.

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

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 its branches, or a 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. The professional completing the review should report any identified discrepancy to necessary parties which could include the pharmacy, medical professional, QIDP or provider administrator as necessary and ensure the discrepancy is corrected.

A physician or pharmacist shall make available to employees, family and customers information on expected consequences, potential benefits and side effects of any prescribed medication.

For customers 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. The assessment is maintained in the customer's file with the residential provider. If there is an abnormal screening based on the assessment, the prescribing professional must be notified.

Use of psychotropic medications to modify or control behaviors or treatment of mental illness is considered 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 Department of Children and Family Services (DCFS) reviews whether 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.

(a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications);

Residential providers subject to medication administration requirements are monitored by the OA for compliance. OA staff monitoring for compliance are all registered nurses. 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) by fax to the OA's Bureau of Quality Management (BQM). The error reports are forwarded to the OA's nurse reviewers for review and follow up with the provider.

59 Ill. Adm. Code 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 customer'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.

(b) the method(s) for following up on potentially harmful practices;

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 a DCFS investigation, and followed up as necessary to ensure that adequate safeguards are in place to prevent future occurrences. Based on the outcome of a DCFS investigation, DCFS makes recommendations to the provider and requires a corrective action plan. In instances where potentially harmful practices are identified, the OA provides technical assistance to the provider.

(c) the state agency (or agencies) that is responsible for follow-up and oversight.

In addition, the OA annually conducts on-site reviews of a representative sample of customers. The OA review team includes Registered Nurses on each review. The team reviews customer 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 customer's finding(s) as well as any other similar practices involving other customers 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 customers until corrective action is implemented can include increased monitoring visits or moving waiver customers either temporarily or permanently to other settings.

OA findings are summarized and reported at the Waiver Quality Management meetings which includes key staff from the OA and MA. The Waiver Quality Management team meets quarterly and develops appropriate system improvements in response to identified trends and concerns. The 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)*
- **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). Residential Habilitation service providers may allow non-licensed direct support persons to administer medications if the provider complies with the Administration of Medication in Community Settings rule (59 Ill. Adm. Code 116).

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 customers with developmental disabilities.

A medical professional must evaluate the ability of the customer to self-administer medications. Ability to self-administer medication must be reassessed at least annually. Customers must be evaluated using OA approved screening and assessment tools, in accordance with 59 Ill. Adm. Code 116.

A prescribing medical professional must provide the written order for a waiver customer to self-administer medications or participate in a self-administration of medication training program based on the results of the customer's evaluation. The order must become part of the customer's record.

The provider must ensure and document the following:

- A prescribing medical professional must be responsible for the medical services provided to customers, and the management of a customer's medications.
- Only a 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 prescribing medical professional. Rubber stamp signatures are not acceptable. All orders must be given as prescribed by the 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 customer's record. These orders must be countersigned or documented by facsimile prescription by the medical professional within ten working days.

OA 59 Ill. Adm. Code 116 permits a registered nurse who has successfully completed the OA/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 customer, the medication, and the dosages. Direct support personnel are authorized to administer only those specific medications to specific customers 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 customer.

The MAR for the current month must be kept with the medications or in the customer'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. Upon the direct instruction of a Nurse-Trainer, authorized direct care staff may indicate on the MAR completion of the following actions: discontinuation of a medication, change in medication schedule, and/or application of a medication information label issued with a medication by a licensed pharmacy. Customer refusal to take a medication must be noted on the MAR and in the customer's record indicating the reason for the refusal the RN Trainer should be notified of the medication refusal.

An individual Medication Administration Record (MAR) must be kept for each customer for medication administered. It must contain at least the following:

- 1) the customer'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) customer's allergies to medication; and
- 9) any special considerations.

For waiver customers 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 customer.

- **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. Medication errors must be documented and are subject to review by the OA. Medication errors which result in an adverse outcome (defined as requiring medical attention) are reported by fax to the OA's Bureau of Quality Management (BQM). The error reports are forwarded to the OA's nurse reviewers for review and follow up with the provider.

- (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; medication omitted entirely; or the customer refuses the medication. 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:

Residential providers subject to medication administration requirements are monitored by the OA and DCFS for compliance. Providers are required to track all medication errors and to report to the OA and DCFS all errors with an adverse outcome (defined as requiring medical attention) by fax to the OA's Bureau of Quality Management (BQM). The error reports are forwarded to the OA's nurse reviewers for review and follow up with the provider.

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 an DCFS investigation, and followed up as necessary to ensure that adequate safeguards are in place to prevent future occurrences.

Also, any medication errors that are reported through the critical incident reporting process are also reviewed by the OA and the MA at the quarterly waiver compliance management meetings.

- **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:

--

- **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 and DCFS for compliance. DCFS annual licensure visits and routine unannounced staff monitoring visits include a review of the medication administration records (MAR) and medication error reports.

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) through the Critical Incident Reporting and Analysis System (CIRAS). 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 a DCFS investigation, and followed up as necessary to ensure that adequate safeguards are in place to prevent future occurrences.

The OA reviews a representative sample of waiver customers annually. The OA review team includes Registered Nurses on each review. The team reviews customer 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 customer'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 representative sample of waiver customers, 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 customer's finding(s) as well as any other similar practices involving other customers 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 customers until a corrective action is implemented can include increased monitoring visits or moving waiver customers either temporarily or permanently to other settings.

OA findings are summarized and reported at the Waiver Quality Management meetings which includes key staff from the OA and MA. The Waiver Quality Management team meets quarterly and develops appropriate system improvements in response to identified trends and concerns. The 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.

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

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

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

Performance Measure:

G1: Number and percent of customers where the customer/guardian received info about how and to whom to report unexplained deaths and A/N/E at the time of each assessment. N: Number of customers where the customer/guardians received info about how and to whom to report unexplained deaths and A/N/E at the time of each assessment. D: Total number customers 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>):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:

G2 Number and percent of unexplained deaths and substantiated incidents of A/N/E reported to the OA where appropriate actions were taken to address incident. N: Number of unexplained deaths and substantiated incidents of A/N/E reported to the OA where appropriate actions were taken to address incident. D: Number of unexplained deaths and substantiated cases of A/N/E.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

OA Reports

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify:	☒ Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

G3:# & % of customer deaths related to a substantiated case of abuse/neglect reported to the OA where appropriate actions were taken to address incident N:# of customer deaths related to a substantiated case of abuse/neglect reported to the OA where appropriate actions were taken to address incident D:Total # of customer deaths related to a substantiated case of abuse/neglect reported to the OA

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA Reports

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

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

- 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:

G4: Number and percent of critical incident trends where systemic intervention was implemented. N: Number of critical incident trends where systemic intervention was implemented. D: Total number of critical incident trends.

Data Source (Select one):

Critical events and incident reports

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly

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

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:

G5:# and % of substantiated incidents of restrictive intervention, including restraints, reported to the OA where appropriate actions were taken to address the incident N: # of substantiated incidents of restrictive intervention, including restraints, reported to the OA where appropriate actions were taken to address the incident. D: Total # of substantiated incidents of restrictive intervention

Data Source (Select one):

Other

If 'Other' is selected, specify:

OA Reports; Substantiated Incidents

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

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

Data Aggregation and Analysis:

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

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

- 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:

G6 Number and percent of direct support staff who received training on alternative practices to restrictive interventions, including restraints and seclusion. N: Number of direct support staff who received training on alternative practices to restrictive interventions, including restraints and seclusion. D: Total number of direct support providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Direct Support Staff Training Report

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

Specify: 		Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

G7 Number and percent of survey respondents who reported being treated well by direct support staff. N: Number of survey respondents who reported being treated well by direct support staff. 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(<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>):
☒ State Medicaid Agency	☐ Weekly	☒ 100% Review
☒ Operating Agency	☐ Monthly	☐ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☐ Representative Sample Confidence Interval =
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☒ Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

G8 Number and percent of customers/guardians reporting that they visited a doctor or practitioner for an annual screening within the last 12 months. N: Number of customers/guardians reporting that they visited a doctor or practitioner for an annual screening within the last 12 months. D: Total number of customer records reviewed.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

G1: The OA will assure that customers know how to report abuse, neglect, or exploitation. This will be demonstrated by correction of case work documentation reflecting customer's awareness, including evidence of steps taken to educate the customer. Remediation must be completed within 30 days.

G2: The OA will follow up all outstanding referrals and substantiated incidents. Changes in customer's PCP, corrective action plans or provider sanctions will be made when needed. Remediation must be completed within 30 days.

G3: The cause of death/circumstances would be reviewed by the OA and need for training or other remediation; including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns. Resolution or remediation timeframe would be case-specific.

G4: The OA will review all outstanding critical incidents with the MA to identify trends and implement systemic interventions, that may include training, a plan of correction, or other remediation to assure that critical incidents are being analyzed to determine root cause. Remediation must be completed within 30 days.

G5: The OA will follow up all outstanding DCFS referrals of substantiated incidents of confinement. Changes in customer's PCP, corrective action plans or provider sanctions will be made when needed. Remediation must be completed within 30 days.

G6: The OA will follow up to ensure that training on alternative practices to restrictive interventions, including restraints and seclusion, within 30 days.

G7: If identifying information is available for individual surveys, the ISC staff will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Patterns of negative responses, including anonymous survey responses, will be used to identify need for system improvement.

G8: During the initial evaluation or redetermination, the ISC staff will ask whether the customer has a primary care doctor or practitioner and whether they had a physical in the last 12 months. If not, barriers will be identified and addressed. Remediation will occur at the meeting between customer and ISC staff.

The OA is responsible for seeing that these individual findings are resolved. The OA provides quarterly reports of these activities to the MA. Staff of the two State agencies review the reports on a quarterly basis.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

☒ No

☐ Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 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 (QIS) 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; and
- 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 QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. 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 3)

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 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). This partnership provides analysis to information derived from discovery and collaboratively develops and monitors remediation activities for each of the federal assurances.

The OA and MA share reports that track changes in compliance levels for performance measures over time. This includes tracking changes across the entire state. This helps to identify problematic areas and potential best practices. Together, the MA and OA aggregate information and generate reports on a quarterly basis.

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 (CIRAS) database. Summary information and trend analysis is discussed during quarterly Waiver Quality Management Committee meetings of the MA and OA staff. Necessary remediation is identified and documented on the System Improvement Log maintained by the MA.

The OA is responsible for the majority of the data collection to address the Quality Management System discovery and remediation activities. The OA is primarily responsible for eligibility and authorizing qualified providers. Therefore, there are distinct performance measures for these functions under the OA. Additionally, as a result of enhancements in the MA's data systems, the MA now includes qualified provider performance measures. The MA is specifically accountable for the measures in Appendix C Qualified Providers. The state's system improvement activities are in response to aggregated and analyzed discovery and remediation data collected on each of the waiver performance measures.

The sources of discovery evidence vary, but all are based on either a 100% review or the representative sampling methodology as indicated for each performance measure. The OA annually selects a representative sample of waiver customers. Onsite, desk audit, remote or virtual, as appropriate, reviews are scheduled and conducted throughout the year at Independent Service Coordination agencies and waiver service providers. Data is collected throughout the year and individual problems are remediated as they are identified. Other data sources include the State Medicaid Management Information System (MMIS) and other reports as indicated in the waiver.

The OA takes a multi-phased and multilevel approach to using reports to improve the overall system. Because changes in the compliance level for a performance measure may be explained by an external factor that would not require remediation (e.g., better targeting of customers with greater impairment than may have an adverse impact on some of the performance measures), the first step is to investigate to try to determine if an actual problem exists. The second step is to formulate potential interventions that may remediate the problem. The third step is to roll out those interventions, possibly on a pilot basis. The final step is to track changes using the original performance measures to assess the impact of intervention.

The state's quality oversight system between the MA and the OA is hierarchical. With regards to waiver management, the process described above is multilevel. The MA oversees the OA, which oversees the ISC agencies, which employs the independent service coordinators. Consequently, the state's quality management system includes regular and structured oversight meetings to facilitate communication, investigation, and problem solving across the many levels. The OA meets with all ISC agencies at least quarterly and meets with a representative sample of independent service coordinators at least annually, and more often if required due to performance issues. The OA and MA meet quarterly.

The Children's Residential Waiver Quality Improvement Plan (QIP) 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 Adults with Developmental Disabilities (0350). 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.

On a quarterly basis, the MA conducts Quality Management Committee (QMC) meetings with the OA to review data collected from the previous quarter and for the year to date. Data is collected on a regular basis and is reported as indicated by the performance measure in the waiver. All reports will be provided to the MA for review prior to the quarterly meetings. Annual reports are produced identifying trends based on the 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 remediations outstanding.

During quarterly meetings, the MA and the OA identify trends based on scope, severity, changes and patterns of compliance by reviewing both the levels of compliance with the performance measures and remediation activities conducted by the OA. Identified trends are discussed and analyzed regarding cause, contributing factors and opportunities for system improvement. Systems improvement is prioritized based on the overall impact to the customers and the program. System improvements may be prioritized based on factors such as: the impact on the health and welfare of waiver customers, legislative considerations, and fiscal considerations. Decisions and timelines for system improvement are based on consensus of priority and specific steps needed to accomplish change. These decisions are documented and communicated through the sharing of the quarterly meeting summary.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
☒ State Medicaid Agency	☐ Weekly
☒ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Quality Improvement Committee	☒ Annually
☐ Other Specify: 	☐ Other Specify:

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

For the OA, the state uses the same mechanisms that it uses to identify potential issues including contract compliance, customer satisfaction, assurances, and critical incident analysis to monitor the effectiveness of all interventions. The state tracks changes in the performance measures using data analysis and reports.

For the OA, customer input also plays a central role in the QIP as follows: Customers' perception of the quality of their services using constructs that are meaningful to customers (e.g., integration in the community, dignity, respect, etc.) as gathered through customer satisfaction tools and the assessment tool. These tools provide the OA with the direct feedback loop about the effect of potential interventions on the quality of life for individual customers.

The processes Illinois follows to continuously evaluate the effectiveness of the QIP are the same processes to evaluate the information derived from discovery and remediation activities. The Waiver Quality Management Committee (QMC) uses documentation 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 customer/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 QIP. System design changes may be specific to the OA or one waiver or may involve multiple waivers. The purpose of meeting annually is to provide an arena to see the system holistically, determine how well the system design changes are working, and identify areas that require further improvement.

In the OA QIP, the State has implemented additional efforts to address its ability to improve and maintain quality. These include:

- 1) Updated performance measures in each of the waiver areas,
- 2) Redesigned reports to be used on a quarterly basis,
- 3) Updated CIRAS Manual updating and clarifying reporting processes, enrollment processes, reporting requirements, definitions of critical incidents Event Report system and clearer delineation of critical incident definitions and follow-up procedures including training for ISCs and service providers on reporting and management of critical events,
- 4) Implementation of new process and tracking system for implementation deadlines for substantiated DCFS and/or APS findings,
- 5) Implementation of additional review questions to evaluate customer satisfaction.

The OA meets with the Developmental Disabilities Advisory Committee (DDAC) multiple times a year to present information about the waiver and receive input from providers, stakeholders, and customer representatives. The DDAC has several temporary work groups to address identified topics, including a technology work group and home-based services work group. This process of inclusion of stakeholders has been most effective and is viewed by the OA as a critical element in its QIP. Meeting dates and times are shared with the MA for their information and participation.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

During the quarterly meetings with the OA, the OA and MA review Performance Measure reporting and the QIP. The OA and the MA discuss updates that both Departments need to address in the future. The OA also seeks input from its DDAC and advocacy groups on improvements and/or changes to the QIP. The OA continually addresses issues as they arise, responds, and implements strategies to improve compliance with performance indicators. The whole QIP is viewed as a continuous ongoing process.

One wavier QMC meeting a year is dedicated to discussing statewide issues impacting the waiver. During this annual meeting, the OA has on the agenda an overview of the previous year's activities and a discussion of whether changes are needed to the QIP. The MA and the OA see five primary focus areas: These areas are described below.

- 1) Structure of the QMC: The group reviews the structure of the QMC to determine if it is effective.
- 2) Trend Analysis: The group evaluates the processes for identifying trends, patterns, and root causes to assure that issues are being identified and analyzed.
- 3) Systems Improvement: The group reviews the QIP documentation to assure that all recommendations have been implemented in accordance with agreed upon timelines, and if not, whether there is justification.
- 4) System Improvement Priorities: The methods for determining system improvement priorities are evaluated to determine effectiveness.
- 5) Performance Measures: The entities determine whether to make changes in existing performance measures, add measures, or discontinue measures. Other elements of performance measures are reviewed for effectiveness, including: the frequency of data collection, source of data, sampling methodology, and remediation.

The state continuously strives to increase the compliance rate of each performance measure. 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, as well as, all entities involve experience staff changes that require ongoing training.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

- ☒ No
- ☐ Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

- ☐ HCBS CAHPS Survey :
- ☐ NCI Survey :
- ☐ NCI AD Survey :
- ☐ Other (*Please provide a description of the survey tool used*):

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).

(a) requirements concerning the independent audit of provider agencies

All providers who receive at least \$500,000 in funding from the OA are reviewed annually. Audit requirements differ depending on the amount paid to the provider by the OA. Providers that receive from \$500,000.00 to \$749,999.99 from the OA must submit a financial statement audit conducted in accordance with Generally Accepted Auditing Standards (GAAS). Providers that receive \$750,000.00 or more through the OA, must submit a financial statement audit conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS). OA staff in the Office of Contract Administration (OCA) review the audits and ensure each agency required to complete an audit have done so. At the conclusion of the audit, a report is emailed to the provider detailing the results. Corrective action plans are required if findings are noted during the review of the provider agency's independent audit report. The letter sent to the provider identifies the findings which need to be corrected, the deadline for submitting the corrective action plans, and where the corrective action plans must be submitted. The Office of Contract Administration (OCA) communicates with the provider to determine when compliance is met. OCA notifies the OA when compliance has been met. When inappropriate claims are identified, the OA works with the provider to correct their billing. If the correction includes a recoupment, the collection occurs through future billings submitted by the provider until the money is recouped. If a correction can't be made by recoupment, the OA submits a request to the DHS, Bureau of Collections (BOC) to establish a collection. The BOC works with the provider until the debt is collected. The system has edits in place to adjust billings to ensure they don't get submitted for FFP.

Failure to comply with reporting requirements shall result in the withholding of funds, the return of improper payments or Unallowable Costs, will be considered a material breach of this Agreement and may be the basis to recover Grant Funds. Grantee's failure to comply with Articles XIII, XIV, or XV of the Uniform Grant Agreements (UGA) shall be considered prima facie evidence of a breach and may be admitted as such, without further proof, into evidence in an administrative proceeding before Grantor, or in any other legal proceeding. Grantee should refer to the State of Illinois Grantee Compliance Enforcement System for policy and consequences for failure to comply. If the OA 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 OA, regardless of overall funding level. Individual providers and businesses that are not under contract with the OA are not required to obtain and submit audits on their financial information. However, the OA reserves the right to audit any provider at any time. Agency scrutiny is triggered in several situations, including where there are complaints about workers that do not show up for a scheduled shift, when staff bill for more services than are on the PCP, or instances where providers submit multiple bills for the same date of service, or bill for customers no longer receiving waiver services. Agency scrutiny is also triggered based on reports the OA gets on totals paid to the 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;

The OCA 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 OA 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 OCA and are available to the OA upon request. 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. The audit process is the same for all providers.

30 ILCS 5/3 specifies the jurisdiction of the Auditor General and section 3-2 identifies the mandatory post audits. The Auditor General shall conduct a financial audit, a compliance audit, or other attestation engagement, as is appropriate to the agency's operations under generally accepted government auditing standards. In conjunction with HFS' portion of the Statewide Single Audit, a sample of provider billings for Medicaid payments that may include billings for Medicaid payments for waiver services is reviewed. The Illinois Office of Auditor General is responsible for conducting the financial audit program.

The MA and OA work cooperatively to review rates and provider claims. The MA implements procedures that provide assurances that claims will be coded and paid in accordance with the reimbursement methodology specified in the waiver. The MA delegates to the OA the financial oversight of claims.

The OA's computer system generates applicable rates and service authorizations according to the waiver program parameters for which the customer is authorized to participate. Each customer's service authorization(s) of which some are

provider agency specific where only the specified provider can bill and receive payment and others are generic where any qualified and enrolled provider can bill and be paid are transmitted from the OA's computer system to the OA's Community Reimbursement Sub-system (CRS). The OA's computer system can either produce individualized or statewide rates as set by the OA's rate setting methodologies. The OA's computer system also transmits the individualized or statewide rates to the OA's (CRS) which maintains a complete historical record of every customer's authorization(s) for services and rates.

CRS also contains each provider's eligibility to provide services and what services the provider is eligible to provide, bill and be paid for. Each provider or provider agency submits billing through the OA's Reporting of Community Services (ROCS) system. ROCS reporting from each provider or provider agency includes the customer's information of the first, last and middle initial of the customer's name, Social Security Number (SSN), Recipient Identification Number (RIN) if one has been assigned, and Date of Birth (DOB). The provider or provider agency also reports specific bill codes for each service delivered, quantity of services delivered and bill rate. All ROCS billing is transmitted to the CRS. The CRS batch processes all ROCS billing on a weekly basis. The CRS has edits which check for the customer's identity against the customer's information in CRS. The customer's Medicaid eligibility on the day services were delivered and being billed for, the customer is authorized for the service being billed and the service was authorized for the date service(s) are being billed. The CRS also compares the provider's billing rate against either the statewide billing rate or the customer's authorized individualized rate for the applicable service and bill code.

The CRS adjudicates all provider billing based on the customer's eligibility for services on the date services were delivered by the provider or provider agency. The CRS performs edit checks that the provider or provider agency is eligible to deliver the service being billed. CRS also adjudicates the payment for services based on the OA's authorized rate for the customer for each service. CRS rejects and does not pay for any services which do not pass all of the above listed edits including services provided before or after a customer's service authorization for each service.

Other edits ensure appropriate billing is submitted by the provider or provider agency include that the CRS reject billing for services prior to the customer's determined date of eligibility for DD services by the ISC.

Another safeguard for all provider billings is that CRS will reject any billing if the billing was previously submitted, adjudicated and paid. Provider agencies cannot bill over the authorized number of units for a day or month of service nor can a provider or provider agency bill over the annually authorized number of units of any specific service for the customer.

The OA reviews 100% of claims verifying the following:

1. The customer was eligible and enrolled in the waiver on the date of service, and,
2. The rates were paid in accordance with the reimbursement methodology.

In addition, the OA reviews rate calculations anytime there is a significant change in the computerized information management system. The MA also reviews the residential rate components calculated by the OA 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 MA review.

Further, the OA selects a representative sample of claims and conducts post-payment reviews to verify whether the services were approved in the PCP. 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 OA selects a statistically valid sample from customers enrolled in the waiver using a 95% confidence level and a +/-5% margin of error and reviews 100% of the claims for the customer for services received. The OA compares the customer's PCP to services billed in order to ensure services were received as identified in the PCP. The OA ensures the provider is enrolled and approved to provide the service. The OA reviews the claims from the last SFY to ensure services were billed and paid accurately according to the waiver. The provider is emailed a report indicating deficiencies identified and if a Corrective Action Plan is required. Annually, the OA selects a statistically valid sample (with a 95% confidence level and a +/-5% margin of error) of providers and conducts an unannounced review to ensure the corrective action plan is being followed.

When inappropriate claims are identified, the OA works with the provider to correct their billing. If the correction includes a recoupment, the collection occurs through future billings submitted by the provider until the money is recouped. If a correction can't be made by recoupment, the OA submits a request to the DHS, Bureau of Collections (BOC) to establish a collection. The BOC works with the provider until the debt is collected. The system has edits in place to adjust billings to ensure they don't get submitted for FFP.

CONTINUE TO MAIN B OPTIONAL

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.

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

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

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

Performance Measure:

I1 Number and percent of payments that were paid for customers who were enrolled in the waiver on the date the service was delivered. N: Number of payments that were paid for customers who were enrolled in the waiver on the date the service was delivered. D: Total number of payments reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS Medical Data Warehouse

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

		95% confidence level with a +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

I2: Number and percent of payments made that were coded and paid only for services rendered as specified in the approved waiver. N: Number of payments made that were coded and paid only for services rendered as specified in the approved waiver. D: Total number of payments reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:

I3 Number and percent of rates that are consistent with the approved rate methodology throughout the five-year waiver cycle. N: Number of rates that are consistent with the approved rate methodology throughout the five-year waiver cycle. D: Total number of rates reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS Medical Data Warehouse

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

☒ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

I1: The MA will require the OA to void the federal claim for services provided prior to the customer's waiver enrollment. Remediation must be completed within 30 days.

I2: The OA will determine whether the service was coded and paid correctly and authorized in the PCP. If missing from the PCP, the PCP will be revised to include the service. If coded and/or paid incorrectly, the OA will void the federal claim and resubmit. Remediation must be completed within 30 days.

I3: The MA will require the OA to either recoup the overpayment or repay at correct rate. If necessary, it will also adjust the federal claim.

Remediation must be completed within 30 days.

The OA is responsible for seeing that these individual findings are resolved. The OA provides quarterly reports of these activities to the MA. Staff of the two State agencies review the reports on a quarterly basis.

ii. Remediation Data Aggregation

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

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☒ **No**

☐ **Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The public input process for amendment of this waiver is detailed in Main Section 6-I.

General

All rate methodologies are established by the OA and reviewed and approved by the MA, that retains final authority over payment rates. The MA 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 customers and guardians (when applicable), family members, ISC's and providers. Copies of rate methodologies are on file with the MA and the OA. Established rates are published on the OA's website at: <https://www.dhs.state.il.us/page.aspx?item=126084>.

Waiver customers, advocates, stakeholders, and other interested parties are notified of changes to an approved waiver through notification from the MA through solicitation of public comment. The MA publishes a notice of the proposed waiver renewal, and the request for comment, electronically their public website at <https://www.illinois.gov/hfs/info/legal/PublicNotices/Pages/default.aspx>. The comment period lasts for 30 days. In addition, the MA also issues notice for tribal notification.

A non-electronic method of public distribution also occurs with postings at DHS local offices throughout the state, except in Cook County. In Cook County, the notice is available at the Office of the Director, Illinois Department of Healthcare and Family Services, 401 South Clinton Street, 1st Floor, Chicago, Illinois. Additionally, a telephone number is provided within the notice for interested parties to request a paper copy of the proposed waiver renewal, if desired. The public notice invites comments via email or regular mail. Finally, Department of Human Services emailed notification to its stakeholders and other interested parties.

Rates for all waiver services are reviewed on an ongoing basis by the MA and OA, at a minimum every five years. The MA and OA work cooperatively to ensure payments are consistent with economy, efficiency, and quality of care and are sufficient to enlist enough providers. This is completed by performing rate studies and comparing states with similar demographic characteristics as Illinois. Rates for waiver services do not differ based on geography or by provider.

IL.0473.R03.00 - 7/1/2022

The rate for Residential Habilitation: Child Group Home (CGH) rates will increase 3% effective July 1, 2022. The Department of Children and Family Services (DCFS) is the licensing authority for CGHs and is responsible for setting rates for the CGHs within their agency. This increase was approved by the Illinois General Assembly to align with a rate increase DCFS authorized for their CGHs so all CGHs remain competitive with reimbursement in the State.

IL.0473.R03.01 - 1/1/2023

The rate for Residential Habilitation: The Department of Children and Family Services (DCFS) is the licensing authority for CGHs and is responsible for setting rates for the CGHs within their agency. DCFS implemented a 10% rate increase in the Spring of 2022 which the OA is implementing effective 1/1/23, or upon CMS approval. This increase was appropriated by the Illinois General Assembly to align with a rate increase DCFS authorized for their CGHs so all CGHs remain competitive with reimbursement in the State. The OA is also implementing a 2% COLA increase for CGHs effective 1/1/23, or upon CMS approval. Therefore, CGH rates will increase by 12% effective 1/1/23, or upon CMS approval.

IL.0473.R03.02 - 7/1/2024

CGH rates will retroactively increase by 8.54%, effective 7/1/24. Since this increase is <10%, the State is requesting a retroactive effective date.

IL.0473.R03.03 , effective 1/1/26

CGH rate will increase 8.8% in response to legislation passed by the Illinois General Assembly as PA104-0002.

IL.0473.R03.04 , effective 1/1/27 or upon CMS approval

CGH rate will increase 3% in response to DCFS rate increases

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

Residential Habilitation: Child Group Home:

These rates were originally established by the OA and approved by the MA in 1994 and have been subject to proposed legislative increases over subsequent years.

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

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

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

The OA will review CFRs submitted by CGHs when requested and adjust Residential Habilitation: Child Group Home rates if appropriate. These rates are subject to COLA increases when approved by the General Assembly. The State establishes a claiming rate to correspond with the Residential Habilitation: Child Group Home payment rate. While the State includes a room and board component in its payment method, all room and board components are excluded from the amount claimed for Medicaid matching funds.

Adaptive Equipment and Assistive Technology:

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

Behavior Intervention and Treatment:

There are two rate levels for this service based on provider qualifications. The higher rate (Level 1) was based on a weighted combination of Bureau of Labor Statistics wage for licensed clinical psychologists with a doctoral degree, provider survey results, and a comparison to bargaining agreement wages for state employees. The lower rate (Level 2) of 80% rate of the higher rate was based on a weighted combination of Bureau of Labor Statistics wage for a master's degree, provider survey results, and a comparison to bargaining agreement wages for state employees. Both rates are subject to cost of living adjustments when enacted. The rate was last set and reviewed in 2020.

- 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

Fee-for-Service providers are paid by the OA. Providers may bill Medicaid directly.

Waiver funding is appropriated to the OA primarily from the State's General Revenue Fund.

The OA maintains a computerized payment system that includes PCP authorization for each customer, payments to provider agencies, units of service delivered to each eligible customer, and payment and claiming rates per unit of service.

The OA authorizes services in advance of service delivery. A voucher document is utilized in this payment process and constitutes a legal agreement between the OA and the provider.

The OA payment system contains edits to ensure that payments are made only when the customer is authorized for the program services delivered, via the PCP that specifies the program services, the provider of the program services, the amount the services authorized, providers that are properly enrolled for the services delivered, and that payment is made at the correct payment rate.

The OA's software system processes all parts of the billings and claims but the State's Comptroller creates the payment vouchers to pay the provider agencies. There is a three-party Medicaid Waiver provider agreement (HFS 1413) between the provider, the OA and the MA.

OA Claims Processing

Information from the OA's computerized payment system feeds into the computerized claiming system that contains edits to ensure that the customer has been determined to meet the ICF/IID level of care prior to the date of service. The OA 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 OA claiming system subtracts from the Waiver claim the spenddown obligation of each customer, if any (available on a monthly extract from the MA's MMIS system).

Valid billing submissions are submitted to the MA on a weekly basis, to determine Medicaid eligibility. The MA then returns a weekly file to the OA with an OBRA indicator code for all those customers who met the eligibility criteria. Customers who were not returned with an OBRA indicator code are researched by the OA staff and re-submitted. If issues are corrected, the MA will provide the OA OBRA indicator code. All billings that were accepted by the MA from OA with the OBRA indicator code are eligible for federal financial participation. Federal financial claiming is submitted by MA.

Payments are made by the State of Illinois Comptroller's Office from OA appropriation. The OA then submits the amount of expenditures for Medicaid eligible customers to the MA for submission of federal financial participation.

MA's Claims Processing

The OA Waiver claiming data are transmitted to the MA via a weekly computer tape exchange. The Waiver subsection of the MMIS matches the customer against the recipient eligibility file to ensure Medicaid eligibility on the date of service and verifies the provider is enrolled as a Waiver provider with the MA. 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. MMIS includes edits for waiver claims that conflict with other waivers, hospitals, nursing home, hospice facilities, or institutional 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 customers 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 OA to verify the effective date of each waiver service authorized in the customers PCP and the customer's level of care eligibility. Providers are required to certify billings are true and accurate through the ROCS billing system which transmits the billing information to the Community Reimbursement Subsystem (CRS). The CRS has edits in place which conduct checks to ensure the customer has Medicaid coverage on the date the service is provided and billed, and the customer is authorized to receive the service.

Provider billings are validated by the OA to verify the effective date of the customer's eligibility and authorization for services according to the approved PCP. If inappropriate billing is discovered, the claim is adjusted or voided by the OA to reduce the state's claim for FFP. The OA will contact the provider to collect any overpayment. The OA will also void or adjust any claims related to the restitution. 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.

Residential Habilitation: Child Group Home provider billings are validated by the OA to verify the effective date of the customer's authorization for services are rendered according to the approved PCP. The provider submit bills directly to the OA through the ROCS billing system. Through a statically valid representative sample, using a 95% confidence level and a +/-5% margin of error, OA staff verify that services were rendered in accordance with the authorizations and the PCP. Service delivery is compared with the services authorized and services included in the customer's PCP, as well as through communication with the customer. Verification of service provision is also monitored by ISC staff during contact with the customer to determine if services are being received by the customer as authorized and detailed in PCP. When inappropriate claims are identified, the OA staff work with the provider to correct their billing. Voided claims reduces the state's claim for FFP through an adjustment process. If the correction includes a recoupment, the collection occurs through future billings submitted by the provider until the money is recouped. If a correction can't be made by recoupment, the OA submits a request to the DHS, Bureau of Collections (BoC) to establish a collection. The BoC works with the provider until the debt is collected. The system has edits in place to adjust billings to ensure they don't get submitted for FFP.

Paid Claims are passed through to the MA and MMIS processing edits are initiated for Medicaid and waiver eligibility. Lastly, the MA performs post-payment personal plan and financial reviews.

Oversight to ensure that appropriate services were provided occurs through the OA's computer system. The OA's computer system generates applicable rates and service authorizations according to the waiver program parameters for which the customer is authorized to participate. Each customer's service authorization(s) of which some are provider agency specific where only the specified provider can bill and receive payment and others are generic where any qualified and enrolled provider can bill and be paid are transmitted from the OA's computer system to the OA's Community Reimbursement Sub-system (CRS). The OA's computer system can either produce individualized or statewide rates as set by the OA's rate setting methodologies. The OA's computer system also transmits the individualized or statewide rates to the OA's (CRS) which maintains a complete historical record of every customer's authorization(s) for services and rates.

CRS also contains each provider's eligibility to provide services and what services the provider is eligible to provide, bill and be paid for. Each provider or provider agency submits billing through the OA's Reporting of Community Services (ROCS) system. ROCS reporting from each provider or provider agency includes the customer's information of the first, last and middle initial of the customer's name, Social Security Number (SSN), Recipient Identification Number (RIN), and Date of Birth (DOB). The provider or provider agency also reports specific bill codes for each service delivered, quantity of services delivered and bill rate. All ROCS billing is transmitted to the CRS. The CRS batch processes all ROCS billing on a weekly basis. The CRS has edits which check for the customer's identity against the customer's information in CRS. The customer's Medicaid eligibility on the day services were delivered and being billed for, the customer is authorized for the service being billed and the service was authorized for the date service(s) are being billed. The CRS also compares the provider's billing rate against either the statewide billing rate or the customer's authorized individualized rate for the applicable service and bill code.

The CRS adjudicates all provider billing based on the customer's eligibility for services on the date services were delivered by the provider or provider agency. The CRS performs edit checks that the provider or provider agency is eligible to deliver the service being billed. CRS also adjudicates the payment for services based on the OA's authorized rate for the customer for each service. CRS rejects and does not pay for any services which do not pass all of the above listed edits including services provided before or after a customer's service authorization for each service.

Other edits ensure appropriate billing is submitted by the provider or provider agency include that the CRS reject billing for services prior to the customer's determined date of eligibility for DD services by the ISC.

- 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 MA, the OA makes payments from a central computer system. Providers may also bill Medicaid directly. On a weekly basis, waiver claims are edited and sent to the MA for Medicaid claiming. The audit trail is established through State agency approved rates, PCP authorization, documentation of service delivery, and computerized payment and claiming systems cross-matched with the MA, MMIS system.

The OA performs a post payment review of waiver claims, using a statistically valid representative sample with a 95% confidence level and a +/-5% margin of error. The post payment review looks at whether the services were specified in the PCP. The OA reviews a representative sample of claims to determine whether the customer 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:

- ☐ **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, Department of Human Services, Division of Developmental Disabilities

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.

- ☐ 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 section 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 section 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 section 1915(b)/section 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 section 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 section 1115/section 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 section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.
- ☐ If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver 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 section 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.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

- ☐ Appropriation of State Tax Revenues to the State Medicaid Agency
- ☒ Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Funds are directly appropriated by the Illinois General Assembly from the General Revenue Fund to the OA. The funds are not transferred.

- ☐ Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

- ☒ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

- ☒ **Applicable**

Check each that applies:

- ☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- ☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

- ☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

- ☒ **The following source(s) are used**

Check each that applies:

- ☐ **Health care-related taxes or fees**

- ☐ **Provider-related donations**

- ☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

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 OA 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 customers 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 customer's needs that are not covered elsewhere.

The OA 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	157889.72	8428.33	166318.05	206828.40	4734.32	211562.72	45244.67
2	182170.75	9144.74	191315.49	213669.18	5152.07	218821.25	27505.76
3	187613.27	9922.04	197535.31	219424.25	5573.36	224997.61	27462.30
4	193215.33	10765.41	203980.74	226006.98	6047.09	232054.07	28073.33
5	198986.82	11680.47	210667.29	232787.19	6561.10	239348.29	28681.00

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (1 of 9)**

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

Table: J-2-a: Unduplicated Participants

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

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 4	295		295
Year 5	295		295

Appendix J: Cost Neutrality Demonstration

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

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

IL.0473.R03.00 - 7/1/2022

The average length of stay is estimated based on the actual length of stay for individuals who received Waiver Child Group Home services as reported on the CMS 372 reports and current data. Due to the small size of this waiver, the ALOS can fluctuate from year to year.

IL.0473.R03.01 - 1/1/2023

The average length of stay (ALOS) is based on assumptions for phase-in frequency, overall enrollment growth, and continuing participants. The enrollment phase-in frequency assumptions were developed using data from MMIS from January 2017 through September 2021. Assumptions for continuing participants and enrollment growth were developed based on enrollment data from MMIS from January 2017 through September 2021 and assumptions in the previous waiver period. Reasonableness of overall ALOS assumptions were assessed by comparing to CMS 372(S) reports from SFY 2019 (WY2) and SFY 2020 (WY3).

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Factor D for the five year waiver cycle was projected in the following manner:

Unduplicated users for each waiver service:

IL.0473.R03.00 - 7/1/2022

The total unduplicated customers receiving each waiver service is based upon paid claims in MMIS during state fiscal years 2016 through 2020.

The number of unduplicated customers receiving Assistive Technology increases throughout the five waiver years based upon the state's expectation increased utilization of this benefit due to more communication with the eligible population.

IL.0473.R03.01 - 1/1/2023

The assumptions and methodology for the unduplicated users for each waiver service, except Child Group Home, are consistent with the waiver renewal (IL.0473.R03.00 - 7/1/2022) except that a minimum of 10 users is assumed for each service in order to avoid the need for an amendment in the future should the number of users change by an amount that would have an immaterial impact to the total cost of waiver services.

Initial estimates for the Child Group Home service in the renewal, IL.0473.R03.00 effective 7/1/2022, were less than the number of waiver slots from the prior filing. CMS notified the MA that they must maintain the same number of waiver slots as the prior filing in order to meet the maintenance of effort requirement of section 9817 of the ARP. However, no changes were made to the rest of Appendix J to reflect the increase in unduplicated participants. As a result, the original waiver renewal contains some issues which are resolved by this waiver amendment, IL.0473.R03.01 effective 1/1/2023. The increase of 107 utilizers of the Child Group Home service corresponds to the increase of 107 unduplicated participants when comparing initial estimate of unduplicated participants and the 295 unduplicated participants approved in the waiver renewal.

Average units per user:

IL.0473.R03.00 - 7/1/2022

The average units per user for each waiver service in waiver year 1 is based on paid claims in MMIS under this waiver for state fiscal years 2016 through 2020. Amounts for waiver years 2 through 5 were calculated by multiplying the prior year average units per user by the change in ALOS between waiver years. The ALOS was projected to be unchanged for the five year waiver cycle. As a result, average units per user remains unchanged.

IL.0473.R03.01 - 1/1/2023

The average units per user assumption is 95% of the ALOS based on observed utilization patterns in the CMS 372 reports for SFY 2016 through SFY 2019. As the number of unduplicated participants was increased in this amendment, IL.0473.R03.01 effective 1/1/2023, the percentage assumption is unchanged, but the increase in ALOS results in a higher number of average units per user. The increase to 295 unduplicated participants increases the ALOS to 335 days in non-leap years.

Average cost per unit:

IL.0473.R03.00 - 7/1/2022

The average cost per unit is based on the current fee schedules for the Child Group Home service. Cost per unit for other services are based on paid claims in MMIS under this waiver for state fiscal years 2016 through 2020.

The rates for Child Group Home and Behavioral Intervention and Treatment are subject to appropriations by the General Assembly. The OA suggested a 1.5% increase as a planning factor for these services.

For Adaptive Equipment and Assistive Technology, a 2.5% cost per unit trend was used based on anticipated consumer price index (CPI) increases. The following figure illustrates average Chicago-Naperville-Elgin CPI price changes for the most recent five years pulled from the U.S. Bureau of Labor Statistics website. Early CY 2022 data is significantly higher. We think a long-term trend assumption of 2.5% is reasonable given this information.

IL.0473.R03.01 - 1/1/2023

The average cost per unit for Child Group Home was amended to reflect reimbursement information not known at the time of the waiver renewal. Fee schedules effective April 1, 2022, and an expected reimbursement increase of 12% effective January 1, 2023, are included in the average cost per unit. Fee schedules are available at: <https://www.dhs.state.il.us/page.aspx?item=146866>. Provider fee schedules were composited July 25, 2022, using Healthcare and Family Services (HFS) census data.

An increased projected cost per unit trend of 3% for Child Group Home is reflected based upon historical cost changes for July 2018 through May 2022 from MMIS and exercising actuarial judgement.

The estimates in the previously approved waiver (IL.0473.R03.00 effective 7/1/2022) were developed based on rates provided by the operating agency in December 2021. The increase in WY 1 cost per unit is because of fee schedule information not known at the time of the original filing and unrelated to the 12% or 3% rate increases.

IL.0473.R03.02 - 7/1/2024

The CGH rate will retroactively increase by 8.54%, effective 7/1/24. Since this increase is <10%, the State is requesting a retroactive effective date.

IL.0473.R03.03 , effective 1/1/26

CGH rate will increase 8.8% in response to legislation passed by the Illinois General Assembly as PA104-0002.

IL.0473.R03.04 , effective 1/1/27 or upon CMS approval

CGH rate will increase 3% in response to DCFS rate increases

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

IL.0473.R03.00 - 7/1/2022

Estimates for Factor D' are based upon paid claims in MMIS during state fiscal years 2018 through 2020, and was trended at a rate of approximately 8.5% per year.

The estimates for Factor D' are based on review of historical data for waiver (Factor D') and institutional (Factor G') populations for SFY 2018 through SFY 2020. The institutional G' population has significantly higher inpatient utilization and costs resulting in the variance between Factors G' and D'. SFY 2020 Factor D' spending per capita, as reported in the 372 report, was trended at a rate of approximately 8.5% per year. The trend is based on the 372 reports for SFY 2016 through SFY 2020 for both IL0473 and IL0464. Data from both waivers were composited for credibility, meaning combining the historical data reduces the element of randomness of trend development.

IL.0473.R03.01 - 1/1/2023

The assumptions and methodology are consistent with the waiver renewal.

- 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:

IL.0473.R03.00 - 7/1/2022

SFY 2020 Factor G spending per capita, using FFS claim experience for institutional recipients ages 3 through 21 with a comparable level of care, and was trended at a rate of approximately 6.0% per year. The trend is based on FFS claim experience for ages 3 through 21 for SFY 2018 through SFY 2020.

IL.0473.R03.01 - 1/1/2023

In the development of this waiver amendment, it was determined that the population used to develop Factor G in the waiver renewal (IL.0473.R03.00) was not the most comparable population to enrollees in the Children's Residential Waiver, IL.0473. The population used in the renewal had a disproportionate prevalence of individuals with an ICF/IID level of care with a high prevalence of medically complex needs, whereas the children in the waiver have a high prevalence of high behavioral needs. After detailed review, the comparable population has been modified to include only enrollees in the Family Support Program (FSP) and State Operated Developmental Centers (SODCs) with an ICF/IID level of care.

The Family Support Program (FSP) provides services for youth with developmental disabilities, severe emotional disturbance, and behavioral support needs. The FSP provides a coordinated system of community-based and residential services, which vary in scope and intensity based upon the needs of the youth and families. The FSP is designed to provide intensive services and supports, including crisis intervention and stabilization, to seek to prevent or limit children and adolescents from cycling through multiple psychiatric inpatient admissions, and to find residential services for those in need. Residential services include child care institutions, group homes, independent living programs, or specialty congregate care programs. Given the similarity of the diagnoses of children and adolescents served by the FSP and those receiving services in IL-0473, the FSP group has been included in the calculation of Factor G.

Costs for Factor G are calculated as a cost per day the member was in an institutional enrollment span, which was developed using admission and discharge data from FSP and SODC claims experience. For cases with a readmission within 61 days of the previous discharge, the customer was considered to retain the same institutional enrollment span. For time periods of up to 61 days before readmission, individuals would be incurring factor G' costs and institutional enrollment span days, but not Factor G costs. For time periods where members were readmitted after more than 61 days, the base data excluded the time between discharge and admission.

For each institutional enrollment span, Factor G claims experience occurring between the admission and discharge date were summarized. The institutional enrollment span length was defined as one plus the difference between the admission and discharge date. The FSP and SODC institutional population was segmented by age group (age 17 and under, age 18 through 21), autism diagnosis, and intellectual disability diagnosis.

A 3.0% cost unit trend per institutional enrollment span day was assumed to Factor G cost. These trend assumptions were developed by reviewing historical data July 2018 through May 2022 from MMIS and exercising actuarial judgement.

Composite estimates for Factor G for waiver years 1 - 5 were developed by weighting the cost per institutional enrollment span day estimates for each subgroup based upon the waive renewal enrollment mix and multiplying the ALOS in IL-0473.

- 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:*

IL.0473.R03.00 - 7/1/2022

SFY 2020 Factor G' spending per capita, using FFS claim experience for institutional recipients ages 3 through 21 with a comparable level of care, and were summarized for each historical waiver year SFY 2018 through SFY 2020. A 6.0% annual trend was selected based upon the children's annual per capita non-institutional cost for the historical period SFY 2016 through SFY 2020. Future waivers years were projected on Factor G' expenditure per unduplicated recipient trend from SFY 2016 through SFY 2020. Factor G' is all such allowable non-waiver related expenditures divided by the number of unique recipients during the waiver year.

IL.0473.R03.01 - 1/1/2023

In the development of this waiver amendment, it was determined that the population used to develop Factor G' in the waiver renewal (IL.0473.R03.00) was not the most comparable population to enrollees in the Children's Residential Waiver, IL.0473. The population used in the renewal had a disproportionate prevalence of individuals with an ICF/IID level of care with a high prevalence of medically complex needs, whereas the children in the waiver have a high prevalence of high behavioral needs. After detailed review, the comparable population has been modified to include only enrollees in the Family Supports Program (FSP) and State Operated Developmental Centers (SODCs) with an ICF/IID level of care.

The Family Support Program (FSP) provides services for youth with developmental disabilities, severe emotional disturbance, and behavioral support needs. The FSP provides a coordinated system of community-based and residential services, which vary in scope and intensity based upon the needs of the youth and families. The FSP is designed to provide intensive services and supports, including crisis intervention and stabilization, to seek to prevent or limit children and adolescents from cycling through multiple psychiatric inpatient admissions, and to find residential services for those in need. Residential services include child care institutions, group homes, independent living programs, or specialty congregate care programs. Given the similarity of the diagnoses of children and adolescents served by the FSP and those receiving services in IL-0473, the FSP group has been included in the calculation of Factor G'.

Costs for Factor G' are calculated as a cost per day the member was in an institutional enrollment span, which was developed using admission and discharge data from FSP and SODC claims experience. For cases with a readmission within 61 days of the previous discharge, the customer was considered to retain the same institutional enrollment span. For time periods of up to 61 days before readmission, individuals would be incurring factor G' costs and institutional enrollment span days, but not Factor G costs. For time periods where members were readmitted after more than 61 days, the base data excluded the time between discharge and admission.

For each institutional enrollment span, Factor G' claims experience occurring between the admission and discharge date were summarized. The institutional enrollment span length was defined as one plus the difference between the admission and discharge date. The FSP and SODC institutional population was segmented by age group (age 17 and under, age 18 through 21), autism diagnosis, and intellectual disability diagnosis.

An 8.5% unit cost trend to Factor G' cost per institutional enrollment span day. These trend assumptions were developed by reviewing historical data July 2018 through May 2022 from MMIS and exercising actuarial judgement.

Composite estimates for Factor G' for waiver years 1 - 5 were developed by weighting the cost per institutional enrollment span day estimates for each subgroup based upon the waive renewal enrollment mix and multiplying the ALOS in IL-0473.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services	
Child Group Home	

Waiver Services	
Behavior Intervention and Treatment	
Adaptive Equipment	
Assistive Technology	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Child Group Home Total:						46072999.70
Child Group Home	Day	295	318.50	490.36	46072999.70	
Behavior Intervention and Treatment Total:						445968.00
Behavior Intervention and Treatment	Hour	150	32.00	92.91	445968.00	
Adaptive Equipment Total:						19500.00
Adaptive Equipment	Per Item	10	1.30	1500.00	19500.00	
Assistive Technology Total:						39000.00
Assistive Technology	Per Item	10	1.30	3000.00	39000.00	
GRAND TOTAL: 46577467.70 Total Estimated Unduplicated Participants: 295 Factor D (Divide total by number of participants): 157889.72 Average Length of Stay on the Waiver: 335						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Child Group Home Total:						53227863.33
Child Group Home	Day	295	318.50	566.51	53227863.32	
Behavior Intervention and Treatment Total:						452544.00
Behavior Intervention and Treatment	Hour	150	32.00	94.28	452544.00	
Adaptive Equipment Total:						19987.50
Adaptive Equipment	Per Item	10	1.30	1537.50	19987.50	
Assistive Technology Total:						39975.00
Assistive Technology	Per Item	10	1.30	3075.00	39975.00	
GRAND TOTAL: 53740369.83 Total Estimated Unduplicated Participants: 295 Factor D (Divide total by number of participants): 182170.75 Average Length of Stay on the Waiver: 336						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Child Group Home Total:						54825140.83
Child Group Home	Day	295	318.50	583.51	54825140.82	
Behavior Intervention and Treatment Total:						459312.00
Behavior Intervention and Treatment	Hour	150	32.00	95.69	459312.00	
Adaptive Equipment Total:						20487.22
Adaptive Equipment	Per Item	10	1.30	1575.94	20487.22	
Assistive Technology Total:						40974.44
GRAND TOTAL: 55345914.48 Total Estimated Unduplicated Participants: 295 Factor D (Divide total by number of participants): 187613.27 Average Length of Stay on the Waiver: 335						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology	Per Item	10	1.30	3151.88	40974.44	
GRAND TOTAL: 55345914.48 Total Estimated Unduplicated Participants: 295 Factor D (Divide total by number of participants): 187613.27 Average Length of Stay on the Waiver: 335						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Child Group Home Total:						56469397.08
Child Group Home	Day	295	318.50	601.01	56469397.08	
Behavior Intervention and Treatment Total:						466128.00
Behavior Intervention and Treatment	Hour	150	32.00	97.11	466128.00	
Adaptive Equipment Total:						20999.42
Adaptive Equipment	Per Item	10	1.30	1615.34	20999.42	
Assistive Technology Total:						41998.71
Assistive Technology	Per Item	10	1.30	3230.67	41998.71	
GRAND TOTAL: 56998523.21 Total Estimated Unduplicated Participants: 295 Factor D (Divide total by number of participants): 193215.33 Average Length of Stay on the Waiver: 335						

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Child Group Home Total:						58163450.80
Child Group Home	Day	295	318.50	619.04	58163450.80	
Behavior Intervention and Treatment Total:						473088.00
Behavior Intervention and Treatment	Hour	150	32.00	98.56	473088.00	
Adaptive Equipment Total:						21524.36
Adaptive Equipment	Per Item	10	1.30	1655.72	21524.36	
Assistive Technology Total:						43048.72
Assistive Technology	Per Item	10	1.30	3311.44	43048.72	
GRAND TOTAL: 58701111.88 Total Estimated Unduplicated Participants: 295 Factor D (Divide total by number of participants): 198986.82 Average Length of Stay on the Waiver: 335						