1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

- Pain and symptom management
- Expressive therapies
- Therapeutic serious illness and bereavement support
- Respite care

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

○	**Not applicable**
◉	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. 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. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☒	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*
	Special Needs Children (SNC) Waiver (IL-02.R01). The SNC Waiver has been previously approved by CMS. An amendment of the SNC Waiver will be approved by the effective date of this SPA.

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

☒	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)

	☐	§1915(b)(2) (central broker)	☒	§1915(b)(4) (selective contracting/limit number of providers)
☒	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*			
	The State Plan benefit covers the State's Managed Care program. The SPA has been previously approved by CMS. An amendment to the 1932(a) SPA to include the additional 1915(i) covered services will be approved by the effective date of this SPA.			
☐	**A program authorized under §1115 of the Act.** *Specify the program*:			

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

◉	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:	
◉	The Medical Assistance Unit *(name of unit)*:	Division of Medical Programs
○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
○	The State plan HCBS benefit is operated by *(name of agency)*	
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.	

4. Distribution of State plan HCBS Operational and Administrative Functions.

☒ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative 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. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute

its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 Eligibility evaluation	☑	☐	☐	☐
3 Review of participant service plans	☑	☑	☑	☐
4 Prior authorization of State plan HCBS	☑	☐	☑	☐
5 Utilization management	☑	☐	☑	☐
6 Qualified provider enrollment	☑	☐	☐	☐
7 Execution of Medicaid provider agreement	☑	☐	☑	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
10 Quality assurance and quality improvement activities	☑	☐	☑	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Healthcare and Family Services (HFS), as Illinois' single state Medicaid agency, retains full authority and responsibility for the operation of the 1915(i) benefit through direct administration and oversight of contracted entities and enrolled service providers. All functions not performed directly by HFS shall be delegated in writing. HFS shall directly supervise the operations and performance of the operating agency and contracted entities, including the review and approval of effective policies and procedures established by such entities. No delegated entity performing any of the 1915(i) benefit operations may substitute its own judgment for that of HFS with respect to the application of rules, regulation, policies, or procedures.

Function 3 - Review of participant service plans.

HFS' contracted University Partner (UP) will develop and maintain service plans for participants in fee-for-service, and the participant's Managed Care Organization (MCO) will develop and maintain service plans for participants enrolled in managed care. HFS provides oversight and monitoring of the UP and MCO performance in development of participant service plans in collaboration with its contracted External Quality Review Organization (EQRO) and Quality Improvement Organization (QIO).

Function 4 - Prior authorization of State plan HCBS.

Prior authorization of State Plan HCBS will be completed by the participant's MCO or by HFS for those participants in fee-for-service.

Function 5 - Utilization management.

Utilization management of State Plan HCBS will be completed by the participant's MCO or by HFS for those participants in fee-for-service.

Function 7 - Execution of Medicaid provider agreement.

MCOs will execute provider agreements with HFS enrolled, qualified providers, allowing those providers to participate in the MCO's provider network.

Function 10 - Quality assurance and quality improvement activities.

HFS contracts with an External Quality Review Organization (EQRO) to conduct quality reviews of MCOs and a Quality Improvement Organization (QIO) to conduct quality reviews of the UP. The EQRO and QIO will conduct annual record reviews to monitor MCO and UP performance in the development of participant service plans. Upon completion of record reviews, a report is submitted to HFS that includes a summary of noncompliance related to specific performance measures; overall summary of record review findings; and recommendations for remediation of non-compliance. HFS, the EQRO, and the QIO work collaboratively to ensure remediation occurs within the required time frames. HFS also reviews for outliers and poor performing measures.

For the performance measures that do not require record reviews, routine reports are submitted to HFS by the MCOs and the UP. HFS will meet bi-annually with the MCOs and the UP to assess compliance with the 1915(i) requirements and to identify trends and determine systemic changes needed to strengthen the quality improvement strategy based upon this analysis. HFS will provide oversight and monitoring of all quality assurance and quality improvement activities.

(By checking the following boxes the State assures that):

5. ☒ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; 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. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. ☒ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☒ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☒**Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	07/01/2023	06/30/2024	200
Year 2			
Year 3			
Year 4			
Year 5			

2. ☒**Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☒ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☒ The State does not provide State plan HCBS to the medically needy.
☐ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. Responsibility for Performing Evaluations / Reevaluations. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

◉	Directly by the Medicaid agency

○	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

Individuals performing evaluations/reevaluations must be licensed as a physician or a registered nurse pursuant to State law and regulations.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The process for evaluating whether individuals meet the 1915(i) needs-based eligibility criteria is described below.

1. **Referral**. The primary care or specialty physician working with a child with a serious illness and their family will make a referral to the UP for the Pediatric Palliative Care Program (PPCP).

2. **Independent Assessment**. An independent assessor at the UP will complete the Illinois Pediatric Palliative Needs Assessment (IPPNA). The IPPNA is an assessment tool developed by HFS to assess a child's need for pediatric palliative care services. The information collected on the IPPNA includes family background, diagnosis, a complete description of the child's current medical condition, type and frequency of needed medical interventions, developmental level of the child, social determinant of health needs, and an assessment of the child's functional needs across the following domains:
   - Cognition – understanding and communicating
   - Mobility – moving and getting around
   - Self-Care – hygiene, dressing, eating, bathing, toileting, continence
   - Getting along – interacting with other people
   - Life activities – use of free/play time, ability to participate in school
   - Participation – joining in community activities, communicating with and understanding other people

   The IPPNA will be administered through a combination of interview with the child and family, clinical consultation with the child's treating providers, and a review of any current clinical documentation provided by the family or the child's treating providers. The independent assessor completing the IPPNA must meet the qualifications as outlined in this application.

3. **Evaluation Review**. The UP will submit the completed IPPNA to HFS. HFS will utilize the IPPNA to determine whether the child meets the needs-based eligibility criteria as outlined below.

4. **Notification**. HFS will notify the child and family of the child's eligibility for the PPCP. This notification will include information about the child's assigned care coordination entity (either through the child's MCO or through the UP for children in fee-for-service) and how to initiate PPCP service planning.

5. **Reevaluation Process.** The child's care coordinator is responsible for maintaining and updating the IPPNA. The IPPNA will be updated annually or more frequently if the child's needs or changes in circumstances deem it necessary. HFS will notify the child, family, and care coordinator when the child's annual reevaluation is coming due. The care coordinator will submit the updated IPPNA to HFS prior to the end of the child's PPCP eligibility period. HFS will complete a reevaluation of eligibility using the updated IPPNA.

4. ☒ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☒ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The State has developed eligibility criteria in accordance with 42 CFR 441.715.

Individuals must meet all the following needs-based criteria:

1. Demonstrate a functional need that requires assistance in at least one of the following areas of major life activity:
   - Activities of daily living;
   - Independent activities of daily living;
   - Mobility;
   - Receptive language;
   - Expressive language;
   - Learning;
   - Self-direction; or
   - Economic self-sufficiency.

2. The child's serious illness places them at a high risk of mortality or premature death.

6. ☒ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
Individuals must meet all the following needs-based criteria: 1. Demonstrate a functional need that requires assistance in at least one of the following areas of major life activity: • Activities of daily living; • Mobility; • Receptive language; • Expressive language; • Learning; • Self-direction; or • Economic self-sufficiency. 2. The child's serious illness places them at a high risk of mortality or premature death.	**Persons with Disabilities:** •Medical determination of a diagnosed, severe disability, which is expected to last for 12 months or for the duration of life. •Be at risk of nursing facility placement as measured by the Determination of Need (DON) assessment. **Persons with Brain Injury (BI)** •Have functional limitations directly resulting from an acquired brain injury as documented by a physician or neurologist. •Be at risk of nursing facility placement as measured by the Determination of Need (DON) assessment. **Persons who are Elderly** •Be at risk of nursing facility placement as measured by the Determination of Need (DON) assessment. **Persons with HIV or AIDS** •Medical determination of	**Support Waiver for Children and Young Adults with Developmental Disabilities:** •Assessed as eligible for an institutional level of care for persons with intellectual disabilities or conditions similar to intellectual disabilities. **Residential Services for Children and Young Adults with Developmental Disabilities** • Children and young adults with developmental disabilities who are at risk of placement in an Intermediate Care Facility for persons with Developmental Disabilities (ICF/DD). • Assessed as eligible for an institutional level of care for persons with intellectual disabilities or conditions similar to intellectual disabilities.	**Medically Fragile, Technology Dependent Children Administrative Agency** • Requires level of care appropriate to a hospital or skilled nursing facility • Meets the minimum score on the Illinois approved Level of Care (LOC) tool **Hospital** •Meets the Interqual criteria for acute hospital care based on the primary diagnosis and clinical presentation of the individual. **Long Term Acute Care (LTAC) Hospital** •Meets the Interqual criteria for long-term acute hospital care based on the primary diagnosis and clinical presentation of the individual. •Condition requires extended 24/7 medically monitored care.

	HIV or AIDS with severe functional limitations, which is expected to last for at least 12 months or for the duration of life • Be at risk of nursing facility placement as measured by the Determination of Need (DON) assessment. **Supportive Living Program** • Found to be in need of nursing facility level of care and Supportive Living Program is appropriate to meet the person's needs.	**Adults with Developmental Disabilities** • Assessed as eligible for an institutional level of care for persons with intellectual disabilities or conditions similar to intellectual disabilities.	

*Long Term Care/Chronic Care Hospital

**LOC= level of care

7. ☒ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Services will be provided to children under the age of 21 who have been diagnosed by a physician with a life-threatening or life-limiting condition.

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☒**Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) 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 person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* 1	
ii.	**Frequency of services**. The state requires (select one):	
	○	**The provision of 1915(i) 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 1915(i) services other than monthly (e.g., quarterly), specify the frequency: At least one 1915(i) service every three months in addition to monthly monitoring.

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☒ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The State plan HCBS benefit will be furnished to eligible individuals who reside and receive HCBS in their home or in the community, not in an institution or institution-like setting.

Participant Residences. The types of residences eligible participants will reside in are:

1) a home or apartment with parents, family, or legal guardian or living independently, that is owned or leased by the individual or their parent or legal guardian. These are not homes or apartments that are owned, leased or controlled by a provider of any health-related treatment or support services; or
2) a licensed foster care home. These settings are the private homes of foster parents who have been determined by the Department of Children and Family Services (DCFS), the State's child welfare agency, to meet a number of standard environmental and physical space dimensions of the home which are geared toward the individual needs of the children who live there. These are not group homes with staff providing services. Foster families are not paid for providing HCBS services to individuals. The licensing rules governing foster care homes ensure that the children placed in these settings are treated the same as any other children in the home. The foster care home licensing rules fully comport with 42 CFR 441.301(c)(4).

Upon enrollment into the 1915(i) benefit, the participant's care coordinator will verify that the participant's residential address meets the HCBS setting requirements. The care coordinator will be required to confirm the participant's residence no less frequently than on a quarterly basis, and participants will be required to contact their care coordinator at any time they relocate. If, during the eligibility period the participant is found to be in an institutional, institution-like, or otherwise non-compliant setting for 30 days or more, the care coordination entity shall notify HFS of the change of status. Any type of institutional or institution-like residence as defined by federal regulations will be considered a non-compliant HCBS setting.

If the participant requires a step-up in level of care to out-of-home care (i.e. long-term hospital, nursing facility, or hospice) the participant will be disenrolled from the 1915(i) benefit and transitioned to appropriate State plan services. HFS will not reimburse HCBS for participants in denied or non-compliant settings pursuant to the 1915(i) authority.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☒ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☒ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

The face-to-face assessment of needs and capabilities will be performed by the individual's care coordinator who must be credentialed as:

- A registered nurse; or
- A Child Life Specialist certified through the Child Life Council; or
- An individual possessing a master's or doctoral degree in counseling and guidance, rehabilitation counseling, social work, psychology, pastoral counseling, family therapy, or a related field who has successfully completed 1,000 hours of practicum and/or internship under clinical and educational supervision.

All persons working on the face-to-face assessment must have at least one-year of supervised clinical pediatric experience in a medical setting and at least one-year clinical end of life care experience or equivalent training and education in end-of-life care. All assessors will receive training in appropriate usage of the IPPNA and must have access to a physician for clinical consultation as needed.

5. **Responsibility for Development of Person-Centered Service Plan**. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

The person-centered service plan will be developed by the individual's care coordinator who must be credentialed as:

- A registered nurse;
- A Child Life Specialist certified through the Child Life Council; or
- An individual possessing a master's or doctoral degree in counseling and guidance, rehabilitation counseling, social work, psychology, pastoral counseling, family therapy, or a related field who has successfully completed 1,000 hours of practicum and/or internship under clinical and educational supervision.

Person-centered service plans must be developed with input from the child's interdisciplinary treatment team, which includes the child, the family, and the child's treating healthcare providers.

6. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

At the initial face-to-face meeting between the care coordinator and the participant and their family, a signed release of information will be obtained (as needed) to allow the care coordinator to request the IPPNA and related PPCP referral information from the UP. The participant will receive a handbook that explains the PPCP, provides information on how to access services, outlines the participant's rights and responsibilities, and outlines the grievance and appeals processes.

The care coordinator informs the participant and their family, as applicable, of their involvement in the development of person-centered service plan and their right to choose who can be involved in the plan development. The participant and their family are given the opportunity to choose the times and location of meeting and the makeup of team membership.

The care coordinator assists the participant, family, and the interdisciplinary treatment team with developing the person-centered service plan. The strengths, needs, preferences, abilities, interests,

goals, and health status of the participant and their family are elicited and prioritized during each step of the person-centered service planning process. Information from the IPPNA and any other medically necessary assessments by qualified providers is used in the person-centered service planning process. The person-centered service plan considers all life domains of the beneficiary, including physical, behavioral, and social health and wellbeing. The care coordinator is responsible for ensuring the person-centered plan is finalized and agreed to, with the informed consent of the participant and their legal guardian in writing and signed by all individuals and providers responsible for its implementation in accordance with the 42 CFR §441.725.

The person-centered service plan is reviewed and revised upon a face-to-face reassessment of the participant's functional needs, as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual. The care coordinator is responsible for in-depth monitoring of the service plan which includes meeting with the participant and their family, as applicable, at least every 90 days to review quality and satisfaction with services, and to assure services are delivered as required and remain appropriate for the individual. This in-depth monitoring by the care coordinator will also include a review of all provider's monthly progress updates. Prior to each annual service plan review, the care coordinator will review the participant rights and responsibilities information with the participant and family if applicable, which includes their right to choose among and between services, providers, and their right to appeal if they are denied the choice of services or provider.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

The care coordinator will inform the participant and their family, verbally and in writing, about their right to choose from among any of the enrolled 1915(i) providers for the chosen services. As a recommended 1915(i) service is identified, the care coordinator will provide the participant with a list of available providers to choose from. The person-centered plan of care signed by the participant and family, as applicable, will contain a statement assuring they had informed choice of providers. The PPCP participant rights and responsibilities document will include information informing participants of their option to change 1915(i) service providers at any time, including the option to change care coordinators, and will outline the process for requesting such changes.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

All person-centered service plans shall be submitted by the participant's care coordinator to HFS electronically, making the plan subject to the approval of HFS. The EQRO and QIO will perform quarterly reviews person-centered service plans to ensure adherence to federal HCBS rules and regulations. Findings of such reviews will be reported to HFS for oversight and management of outcomes.

9. **Maintenance of Person-Centered 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 §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☐	Operating agency	☒	Case manager
☐	Other (*specify):*				

Services

1. State plan HCBS. *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Pain and Symptom Management
Service Definition (Scope)*:*	
Pain and symptom management is defined as nursing care delivered in the home or via telehealth consultation by a pediatric provider or registered nurse from the pediatric interdisciplinary team, to manage the participant's symptoms and pain. Pain and Symptom Management includes regular, ongoing pain and symptom assessments to determine the efficacy of the current regimen and available options for optimal relief of symptoms. Management also includes as-needed visits to provide relief of suffering, during which, providers assess the efficacy of the current pain management regimen is assessed and modified, as needed, to alleviate distressing symptoms and side effects using pharmacological, non-pharmacological, and complementary/supportive therapies.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☒	Categorically needy *(specify limits):*
	The service is automatically authorized for 1915(i) Pediatric Palliative Care Program eligible participants whose service plan recommends Pain and Symptom Management services. Pain and Symptom Management services are to be rendered consistent with frequency, duration, and scope recommended on the service plan. The services under the 1915(i) Pediatric Palliative Care Program are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Pediatric Palliative Care Provider	Providers must be licensed in the state of Illinois as a Hospice Agency, a Home Health Agency, a Home Nursing Agency, a	Providers must be certified by the Medicaid agency to deliver Pediatric Palliative Care.	Pediatric Palliative Care providers must maintain an interdisciplinary team that minimally includes: • A physician, acting as the program medical director, who is board certified or board eligible in pediatrics or hospice and palliative medicine; • A registered nurse; and,

	Federally Qualified Health Center, a Rural Health Clinic or other Encounter Rate Clinic, a hospital, or certified as public health department.		• A licensed social worker with a background in pediatric care. All members of the interdisciplinary team must demonstrate ongoing proficiency in the principles of end-of-life care through participation and successful completion of education and training, the curriculum of which includes instruction in communication with children and families, the grief and bereavement process, and end-of-life care. Staff delivering Pain and Symptom Management services must be licensed as a physician or registered nurse.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Pediatric Palliative Care Provider	HFS	At the time of enrollment and at least every five years thereafter.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Expressive Therapies (art, music, massage, and play therapy)**

Service Definition (Scope)*:*

Expressive Therapies are aimed at assisting children meet the challenges of coping with their serious illness. Included specialty services (i.e., art, music, massage, and play therapy) help children better understand and express their reactions through professionally led creative and kinesthetic treatment modalities designed specifically for the participant. Providers treat emotional distress associated with the participant's diagnosis by providing age-appropriate information about the plan of care, course of treatment, coping with serious illness, and other useful coping strategies to ease anticipatory anxiety regarding upcoming treatments and procedures. Siblings and/or other children who live within the home will be able to attend art, music, or play therapy sessions with the affected child.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):	
☒	Categorically needy *(specify limits):*
	The service is automatically authorized for 1915(i) Pediatric Palliative Care Program eligible participants whose service plan recommends Expressive Therapy services. Expressive Therapy services are limited to five hours per month. The specific service modality (art, music, massage, or play therapy) must be documented on the authorized service plan as a needed service. The services under the 1915(i) Pediatric Palliative Care Program are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Pediatric Palliative Care Providers	Providers must be licensed in the state of Illinois as a Hospice Agency, a Home Health Agency, a Home Nursing Agency, a Federally Qualified Health Center, a Rural Health Clinic or other Encounter Rate Clinic, a hospital, or certified as public health department.	Providers must be certified by the Medicaid agency to deliver Pediatric Palliative Care.	Staff delivering Art Therapy must be credentialed by the Art Therapy Credentials board as a Provisional Registered Art Therapist, a Registered Art Therapist, or a Board-Certified Art Therapist. Staff delivering Music Therapy must be certified by the Certification Board for Music Therapists. Staff delivering Play Therapy must meet any of the following qualifications: • Licensed Clinical Social Worker; • Licensed Social Worker; • Licensed Clinical Professional Counselor; • Licensed Professional Counselor; • Licensed Marriage and Family Therapist; • Licensed Clinical Psychologist; or • Child Life Specialist certified through the Child Life Council. Staff delivering Massage Therapy must be licensed in the state of Illinois as a Massage Therapist.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Pediatric Palliative Care Providers	HFS	At the time of enrollment and at least every five years thereafter.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Therapeutic Serious Illness and Bereavement Support**

Service Definition (Scope)*:*

Therapeutic Serious Illness and Bereavement Support is grief/loss/bereavement or anticipatory grief counseling/support provided to participants and their families to: 1) help the child and family cope with the child's serious illness and treatment process; 2) decrease emotional suffering and distress due to the child's health status; and, 3) develop coping skills to reduce the stress related to living with and caring for the child's serious illness. Therapeutic Serious Illness and Bereavement Support also includes attendance by the counselor at physician visits or hospital discharge planning meetings, as requested by the family, to help the child and family process updates to the child's health status. Services are available to counsel family members and, at the request of the family, persons who provided uncompensated care and support to the family in areas specified on the service plan in dealing with and adjusting to the loss of the child for a period of one year following the death of the child.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒ Categorically needy *(specify limits):*

The service is automatically authorized for 1915(i) Pediatric Palliative Care Program eligible participants whose service plan recommends Therapeutic Serious Illness and Bereavement Support services. Services are to be rendered consistent with frequency, duration, and scope recommended on the service plan. Services may be provided in an individual, family, or group modality and may be rendered in-person, by phone, or by video as necessary to meet the needs of the participant and their family. Services must be requested and documented on the service plan with an anticipated frequency, amount, and duration while the child is participating in the PPCP but may continue, if requested, at no additional charge by the provider for up to one year after the death of the child. Individuals who are employed to support the participant may not receive this service. The services under the 1915(i) Pediatric Palliative Care Program are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Pediatric Palliative Care Providers	Providers must be licensed in the state of Illinois as a Hospice Agency, a Home Health Agency, a Home Nursing Agency, a Federally Qualified Health Center, a Rural Health Clinic or other Encounter Rate Clinic, a hospital, or certified as public health department.	Providers must be certified by the Medicaid agency to deliver Pediatric Palliative Care.	Staff delivering Individual and Family Counseling services must meet one of the following qualifications: • Licensed Clinical Social Worker; • Licensed Social Worker; • Licensed Clinical Professional Counselor; • Licensed Professional Counselor; • Licensed Marriage and Family Therapist; • Licensed Clinical Psychologist; • Child Life Specialist certified through the Child Life Council; or • Non-denominational chaplain or spiritual counselor.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify):*
Pediatric Palliative Care Providers	HFS	At the time of enrollment and at least every five years thereafter

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	**Respite care**
Service Definition (Scope)*:*	
Respite care is provided in the home or in at out of home facility on an intermittent or short-term basis for the provision of care and supportive services to enable the participant to remain in their home or in the community in a home-like environment, while periodically relieving the family of caregiving responsibilities. Respite services mitigate parental distress and burnout by providing caregivers with a period of relaxation free from the caregiving duties. Federal financial participation will not be claimed for the cost of room and board associated with providing out of home respite care.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope	

than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits):*
	The service is automatically authorized for 1915(i) Pediatric Palliative Care Program eligible participants whose service plan recommends Respite Care services. Respite Care services are limited to 14 days or 336 hours annually. Respite Care may only be provided in-person; reimbursement for Respite shall not be available for services rendered telephonically, via videoconference or by members of the child's family. The services under the 1915(i) Pediatric Palliative Care Program are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Pediatric Palliative Care Providers	Providers must be licensed in the state of Illinois as a Hospice Agency, a Home Health Agency, a Home Nursing Agency, a Federally Qualified Health Center, a Rural Health Clinic or other Encounter Rate Clinic, a hospital, or certified as public health department.	Providers must be certified by the Medicaid agency to deliver Pediatric Palliative Care.	Staff delivering services must meet one of the following qualifications: • Registered nurse; • Licensed practical nurse; or • Certified nurse's aide.
Out of Home Respite Providers	Providers must be licensed in the state of Illinois as a children's community-based health center.		Staff delivering services must meet one of the following qualifications: • Registered nurse; • Licensed practical nurse; or • Certified nurse's aide.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*

Pediatric Palliative Care Providers	HFS	At the time of enrollment and at least every five years thereafter.

Service Delivery Method. *(Check each that applies)*:

o	Participant-directed	☒	Provider managed

2. ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

N/A

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. **Election of Participant-Direction**. (S*elect one):*

●	The state does not offer opportunity for participant-direction of State plan HCBS.
O	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
O	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. **Description of Participant-Direction. (Provide an overview of the opportunities for participant-***direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

N/A

3. **Limited Implementation of Participant-Direction**. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

O	Participant direction is available in all geographic areas in which State plan HCBS are available.

○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
N/A	☐	☐
N/A	☐	☐

5. Financial Management. (*Select one)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

N/A

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

●	The state does not offer opportunity for participant-employer authority.
○	Participants may elect participant-employer Authority *(Check each that applies):*

	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

●	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

Requirement		1a) Service plans address assessed needs of 1915(i) participants
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of person-centered service plans that address assessed needs of 1915(i) participants based upon the completed IPPNA. N = number of person-centered service plans that address assessed needs of the 1915(i) participants based upon the completed IPPNA. D = Total number of person-centered service plans reviewed.
	Discovery Activity *(source of data & sample size)*	Source of Data = Record review of 1915(i) participant person-centered service plans. Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	EQRO QIO
	Frequency	Annually.
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS, QIO, EQRO If a Corrective Action Plan (CAP) is needed, it must be provided to the EQRO or QIO within 15 business days. All CAPs are subject to HFS approval. Remediation must be completed within 90 days after the CAP is approved by HFS.
	Frequency *(of Analysis and Aggregation)*	Annually.

Requirement		1b) Service plans are updated at least annually.
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of person-centered service plans reviewed and revised on or before the annual review date.

		N = number of person-centered service plans reviewed and revised on or before the annual review date. D = Total number of person-centered service plans reviewed.
	Discovery Activity *(source of data & sample size)*	Source of Data = Record review of 1915(i) participant person-centered service plans. Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	EQRO QIO
	Frequency	Annually.
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS, QIO, EQRO If a Corrective Action Plan (CAP) is needed, it must be provided to the EQRO or QIO within 15 business days. All CAPs are subject to HFS approval. Remediation must be completed within 90 days after the CAP is approved by HFS.
	Frequency *(of Analysis and Aggregation)*	Annually.

Requirement		1c) Service plans document choice of services and providers.
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of person-centered service plans signed by the 1915(i) participant with documentation of choice of eligible services and available providers. N = number of person-centered plans reviewed that were signed by the 1915(i) participant with documented choice of eligible services and available providers. D = Total number of person-centered service plans reviewed.
	Discovery Activity *(source of data & sample size)*	Source of Data = Record review of 1915(i) participant person-centered service plans. Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.
	Monitoring Responsibilities	EQRO QIO

	(agency or entity that conducts discovery activities)	
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS, QIO, EQRO If a Corrective Action Plan (CAP) is needed, it must be provided to the EQRO or QIO within 15 business days. All CAPs are subject to HFS approval. Remediation must be completed within 90 days after the CAP is approved by HFS.
	Frequency *(of Analysis and Aggregation)*	Annually.

2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

Requirement		2a) An evaluation for 1915(i) State Plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future.
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of participants enrolled within the current month under review with a person-centered service plan indicating they had an evaluation for 1915(i) eligibility based upon the participant's IPPNA prior to enrollment. N = number of participants enrolled within the current month with a person-centered service plan indicating they had an evaluation for 1915(i) eligibility based upon the participant's IPPNA prior to enrollment. D = Total number of person-centered service plans of participants enrolled within the current month reviewed.
	Discovery Activity *(source of data & sample size)*	Source of Data = Record review of 1915(i) participant person-centered service plans. Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	EQRO QIO

	Frequency	Annually
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS, QIO, EQRO If a Corrective Action Plan (CAP) is needed, it must be provided to the EQRO or QIO within 15 business days. All CAPs are subject to HFS approval. Remediation must be completed within 90 days after the CAP is approved by HFS.
	Frequency *(of Analysis and Aggregation)*	Annually.

Requirement		2b) The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of participant eligibility reviews completed according to the process and instruments described in the State Plan Amendment. N = number of participant eligibility reviews completed according to the process and instruments described in the State Plan Amendment. D = Total number of participant eligibility reviews completed.
	Discovery Activity *(source of data & sample size)*	Source of Data = Record review of 1915(i) participants' IPPNA and service plan. Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	HFS
	Frequency	Annually.
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS HFS will establish remediation activities, including a Corrective Action Plan (CAP) as needed, for any identified areas of deficiency. Remediation activities must be completed within 90 days.
	Frequency *(of Analysis and Aggregation)*	Annually.

Requirement		2c) The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of participants whose eligibility was reviewed within 12 months of their previous eligibility review. N = number of 1915(i) participants whose eligibility was reviewed within 12 months of their previous eligibility review. D = Total number of 1915(i) participants whose annual eligibility review was required.
	Discovery Activity *(source of data & sample size)*	Source of Data = Record review of 1915(i) participants' IPPNA and service plan. Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	QIO EQRO
	Frequency	Annually.
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS, QIO, EQRO The QIO and EQRO will identify areas of deficiency in reports submitted to HFS. HFS will establish remediation activities, including a Corrective Action Plan (CAP) as needed. Remediation activities must be completed within 90 days after receipt of the QIO/EQRO reports.
	Frequency *(of Analysis and Aggregation)*	Annually.

3. Providers meet required qualifications.

Requirement		3a) Providers meet required qualifications (initially)
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of service providers who initially met required provider qualifications prior to furnishing 1915(i) services. N = number of service providers who met required qualifications prior to furnishing 1915(i) services. D = Total number of 1915(i) authorized service providers.

	Discovery Activity *(source of data & sample size)*	Source of Data = HFS IMPACT system 100% review.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	HFS
	Frequency	Continuous and ongoing.
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS If a newly enrolled 1915(i) service provider fails initial IMPACT provider requirements, HFS informs the provider of the disposition of the application and does not enroll the provider into the Medicaid system.
	Frequency *(of Analysis and Aggregation)*	Continuous and ongoing.

Requirement		3b) Providers meet required qualifications (ongoing)
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of enrolled service providers who continue to meet 1915(i) provider requirements prior to continuing to provide 1915(i) services. N = number of enrolled service providers who continue to meet 1915(i) provider requirements prior to continuing to provider 1915(i) services. D = Total number of enrolled 1915(i) service providers.
	Discovery Activity *(source of data & sample size)*	Source of Data = HFS IMPACT system 100% review.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	HFS
	Frequency	Continuous and ongoing.
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS If an existing provider fails monthly screening or HFS provider revalidation, HFS notifies the provider of the results and disenrolls the provider.
	Frequency	Continuous and ongoing.

	(of Analysis and Aggregation)	

4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

Requirement		4) Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of participants whose person-centered service plan indicate the participant resides in and receives services in a compliant home and community-based setting as specified by this SPA and in accordance with 42 CFR 441.710(a)(1) and (2). N = number of participants whose person-centered service plan documents the participant resides in and receives services in a compliant home and community-based setting. D = Total number of 1915(i) participant's person-centered service plans reviewed.
	Discovery Activity *(source of data & sample size)*	Source of Data = Record review of 1915(i) participant person-centered service plans. Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	EQRO QIO
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS, QIO, EQRO If a Corrective Action Plan (CAP) is needed, it must be provided to the EQRO or QIO within 15 business days. All CAPs are subject to HFS approval. Remediation must be completed within 90 days after the CAP is approved by HFS.
	Frequency *(of Analysis and Aggregation)*	Annually.

5. The SMA retains authority and responsibility for program operations and oversight.

Requirement	5a) The SMA retains authority and responsibility for program operations and oversight.

Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of quarterly meetings between HFS and its contracted entities (MCOs, the UP) where the contracted entity's performance on delegated functions was reviewed as specified in the SPA. N = number of quarterly meetings between HFS and its contracted entities where the contracted entity's performance on delegated functions was reviewed as specified in the SPA. D = Total number of quarterly meetings between HFS and its contracted entities.
	Discovery Activity *(source of data & sample size)*	Source of Data = Meeting agendas and minutes 100% review
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	HFS
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS HFS will establish remediation activities, including a Corrective Action Plan (CAP) as needed, for any identified areas of deficiency. Remediation activities must be completed within 90 days.
	Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement		5b) The SMA retains authority and responsibility for program operations and oversight.
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of annual performance reports from contracted entities (MCOs, the UP) reviewed to ensure administrative oversight. N = number of annual performance reports from contracted entities (MCOs, the UP) submitted timely and reviewed to ensure administrative oversight. D = Total number of annual performance reports due.
	Discovery Activity *(source of data & sample size)*	Source of Data = Contracted entities' Annual Reports 100% review
	Monitoring Responsibilities	HFS

	(agency or entity that conducts discovery activities)	
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS HFS will require completion and submission of overdue reports. If a Corrective Action Plan (CAP) is needed, it must be provided to HFS within 15 business days. HFS will respond within 15 business days. Remediation must be completed within 30 business days after the response from HFS.
	Frequency *(of Analysis and Aggregation)*	Annually.

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

Requirement		6a) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of claims for 1915(i) services paid for participants who were eligible for the 1915(i) benefit on the date the service was delivered. N = number of claims for 1915(i) services paid for participants who were eligible for the 1915(i) benefit on the date the service was delivered. D = Total number of claims paid for 1915(i) services furnished.
	Discovery Activity *(source of data & sample size)*	Source of Data = MMIS Medical Data Warehouse, MCO Encounter Data 100% review.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	HFS MCOs
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS HFS will require MCOs or providers to void any inappropriate claims for 1915(i) services that were paid. Remediation must be completed within 30 business days.
	Frequency	Annually.

	(of Analysis and Aggregation)	

Requirement		6b) The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of claims paid according to the published fee schedule during the review period. N = number of claims paid according to the published fee schedule during the review period. D = Total number of claims paid during the review period.
	Discovery Activity *(source of data & sample size)*	Source of Data = MMIS Medical Data Warehouse, MCO Encounter Data 100% review.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	HFS MCOs
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS HFS will require MCOs to correct the incorrect rate and if needed will correct the rate in its MMIS system. If necessary, HFS will also adjust federal claims submitted. Remediation must be completed within 30 business days.
	Frequency *(of Analysis and Aggregation)*	Annually.

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

Requirement		7a) The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of incidents reported within required timeframes. N = number of incident reports submitted within required timeframes. D = Total number of incident reports submitted.
	Discovery Activity	Source of Data = record review of submitted incident reports 100% review.

	(source of data & sample size)	
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	HFS MCOs
	Frequency	Continuous and ongoing
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS MCOs Incident reports submitted to HFS or MCOs within 72 hours. State will review and respond within 5 business days. If a Corrective Action Plan (CAP) is needed, it must be provided to HFS or the appropriate MCO within 15 business days. HFS or the MCO will respond within 15 business days. Remediation must be completed within 30 business days after the response from HFS or the MCO.
	Frequency *(of Analysis and Aggregation)*	Continuous and ongoing.

Requirement		7b) The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of person-centered service plans with participant's signature indicating they were informed of their rights surrounding abuse, neglect, exploitation, use of restraints, and reporting procedures. N = number of person-centered service plans with participant's signature indicating they were informed of their rights surrounding abuse, neglect, exploitation, use of restraints, and reporting procedures D = Total number of person-centered plans of care reviewed.
	Discovery Activity *(source of data & sample size)*	Source of Data = Record review of 1915(i) participant person-centered service plans. Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	EQRO QIO
	Frequency	Annually
Remediation		

	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS, EQRO, QIO If a Corrective Action Plan (CAP) is needed, it must be provided to the EQRO or QIO within 15 business days. All CAPs are subject to HFS approval. Remediation must be completed within 90 days after the CAP is approved by HFS.
	Frequency *(of Analysis and Aggregation)*	Annually

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☒	HCBS Respite Care
	HCBS Respite Care rates are on a fee schedule and were established by comparing the services to similar covered Medicaid services. Reimbursement is made at the lesser of the usual and customary charge to the general public or the maximum fee schedule rate established by the Department. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate will be set as of July 1, 2023 and is effective for services provided on or after that date. All rates are published on the Department's website located at http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/.
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☒	Other Services (specify below)
	HCBS Nursing for Pain and Symptom Management HCBS Nursing for Pain and Symptom Management rates are on a fee schedule and were established by comparing the services to similar covered Medicaid services.

	Reimbursement is made at the lesser of the usual and customary charge to the general public or the maximum fee schedule rate established by the Department. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate will be set as of July 1, 2023 and is effective for services provided on or after that date. All rates are published on the Department's website located at http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/.
	HCBS Expressive Therapies HCBS Expressive Therapy rates are on a fee schedule and were established by comparing the services to similar covered Medicaid services. Reimbursement is made at the lesser of the usual and customary charge to the general public or the maximum fee schedule rate established by the Department. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate will be set as of July 1, 2023 and is effective for services provided on or after that date. All rates are published on the Department's website located at http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/.
	HCBS Therapeutic Serious Illness and Bereavement Support HCBS Therapeutic Serious Illness and Bereavement Support rates are on a fee schedule and were established by comparing the services to similar covered Medicaid services. Reimbursement is made at the lesser of the usual and customary charge to the general public or the maximum fee schedule rate established by the Department. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate will be set as of July 1, 2023 and is effective for services provided on or after that date. All rates are published on the Department's website located at http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/.

State: Illinois

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Clinic services	3.1-A	4	9
Dental services	3.1-A	4	10
Physical Therapy	3.1-A	4	11. a
Occupational Therapy	3.1-A	4	11. b
Speech Pathology and Audiology services	3.1-A	4	11. c
Prescribed Drugs	3.1-A	5	12. a
Dentures	3.1-A	5	12. b
Prosthetic devices	3.1-A	5	12. c
Eyeglasses	3.1-A	5	12. d
Diagnostic services	3.1-A	5	13. a
Screening services	3.1-A	6	13. b
Preventive services	3.1-A	6	13.c
Rehabilitative services	3.1-A	6	13. d
Services for individuals age 65 or older in IMDs	3.1-A	6	14. a-c
Intermediate care facility services	3.1-A	7	15. a
Intermediate care facility services – public institution	3.1-A	7	15. b
Inpatient psychiatric facility services for individuals under 22	3.1-A	7	16
Hospice	3.1-A	7	18
Case management	3.1-A	8	19. a
TB related services	3.1-A	8	19. b
Extended pregnancy services for women	3.1-A	8	20. a-b
Ambulatory prenatal care for pregnant women during a presumptive eligibility period by a qualified provider	3.1-A	8A	21
Nurse Practitioner Services	3.1-A	2; 7; 8A	5. a; 17; 23
Transportation	3.1-A	9	24. a
Nursing facility services for patient under 21	3.1-A	9	24. d
Emergency hospital services	3.1-A	9	24. e
Program of All-Inclusive Care for Elderly	3.1-A	10	27
Freestanding Birth Center Services	3.1-A	10A	28
All 1915(c) Persons with Disabilities Waiver covered services – IL.0142			
All 1915(c) Persons with Brain Injury Waiver covered services – IL.0329			
All 1915(c) Persons with HIV or AIDS Waiver covered services – IL.0202			
All 1915(c) Supportive Living Program Waiver covered services – IL.0326			
All 1915(c) Persons who are Elderly Waiver covered services – IL.0143			
1915(i) Children's Mental Health Home and Community Based Services - Care Coordination and Support, Family Peer Support, Intensive Home-Based Services, Respite, and Therapeutic Mentoring	3.1-i	1-52	
1915(i) Pediatric Palliative Care services	3.1-i	53-95	