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):*

HFS will organize its 1915(i) benefit in the following manner:

Component 1. 1915(i) Children's Mental Health - Home and Community-based Services (CMH-HCBS):

- Care Coordination and Support (CCS)
- Family Peer Support
- Intensive Home-Based Services
- Respite
- Therapeutic Mentoring
- Therapeutic Support Services
- Individual Support Services

Component 2. 1915(i) HCBS:

- Supported Employment
- Housing Supports

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:*

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:*
☒	**A program authorized under §1115 of the Act.** *Specify the program*: Behavioral Health Transformation 1115 Waiver

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.

Delegation of Functions. All functions not performed directly by HFS shall be delegated in writing. HFS shall directly supervise the operations and performance of all 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.

Contracted Entities. Illinois Contracted entities utilized for the administration of the 1915(i) benefit will be: 1) HFS contracted Managed Care Organizations (MCOs); 2) Third-party Administrators (TPA); and 3) University Partners (UP).

1. Individual State Plan HCBS enrollment.

For Component 1, HFS shall be responsible for the identification of children meeting the HFS established clinical eligibility criteria to participate in the 1915(i) benefit. For Component 2, a TPA shall be responsible for the identification of individuals meeting the HFS established clinical eligibility criteria to participate in the 1915(i) benefit.

2. Eligibility evaluation.

For Component 1, Community-based Behavioral Health (CBH) providers shall perform initial independent evaluations, and Care Coordination and Support Organizations (CCSO), described in the Care Coordination and Support service below, shall be responsible for the independent re-evaluation.

For Component 2, a TPA shall perform independent evaluation and re-evaluations. The TPA for individuals enrolled in an MCO shall be their MCO, while the TPA for individuals in fee-for-service shall be a contracted community organization. Clinical review and monitoring of participant evaluations shall be performed by the UP.

3. Review of participant service plans.

For Component 1, CCSOs shall review participant service plans.

For Component 2, a TPA shall develop and review participant service plans. The TPA for individuals enrolled in one of HFS' MCOs shall be their MCO, while the TPA for individuals in fee-for-service shall be a contracted community organization. Clinical review and monitoring of participants shall be performed by the UP.

4. Prior authorization of State plan HCBS.

For Component 1 and 2, prior authorization of State plan HCBS services shall be completed by the individual's MCO. For those individuals in fee-for-service, prior authorization of State plan HCBS services shall be provided by the UP.

5. Utilization management.

For Component 1 and 2, utilization management of State Plan HCBS services shall be completed by the individual's MCO. For those individuals in fee-for-service, utilization management of State Plan HCBS services shall be provided by the UP.

6. Qualified provider enrollment.

HFS shall be solely responsible for establishing qualifications for providers of all 1915(i) benefit services and enrolling entities willing to meet those qualifications.

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.

8. Establishment of a consistent rate methodology for each State plan HCBS.

HFS shall be solely responsible for the establishment of rates and rate methodologies for each 1915(i) benefit service.

9. Rules, policies, procedures, and information development governing the State plan HCBS benefit.

HFS shall be responsible for establishing state administrative rules governing the delivery of the 1915(i) benefit. Additionally, HFS (for fee-for-service) and MCOs (for individuals enrolled in managed care) shall establish applicable policies and procedures for the consistent delivery of the 1915(i) benefit. HFS shall review and approve all policies established by its contracted MCOs to ensure compliance and adherence to HFS standards for the delivery of the 1915(i) benefit. CCSOs and TPAs may establish organizational policies for the local management and delivery of 1915(i) benefit. The UP shall review providers to ensure compliance with HFS' standards in the delivery of the 1915(i) benefit.

10. Quality assurance and quality improvement activities.

HFS shall be responsible for the identification and establishment of quality assurance and quality improvement metrics and activities. MCOs (for individuals enrolled in managed care) and the UP (for fee-for-service) shall collect, analyze, and report on quality assurance metrics and quality improvement activities established and performed with providers of the 1915(i) benefit.

(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):*

According to data available on the Health Resources and Services Administration (HRSA) website: data.hrsa.gov, Illinois has multiple areas designated as Medically Underserved Areas/Populations (MUA/P – Health Resources and Services Administration, HHS). These MUA/P designations have an inverse correlation and alignment with population density mapping and a direct correlation with income/poverty mapping, both informed from 2010 US Census Bureau data (census.gov).

Based upon the geographic and population challenges faced by rural Illinois, it is expected that there will be geographic areas where a single entity may be the only entity willing to meet the qualifications to provide all the 1915(i) benefit services. In this situation, some individuals may receive an evaluation and service plan developed by the same provider who is also responsible for the delivery of services under the 1915(i) benefit.

To prevent conflict of interest in these circumstances, HFS has established multiple layers of protection for quality of care and individual choice, as detailed below:

1. An eligible individual and family's choice to participate in services is the first protection against conflict of interest. The eligible individual and/or their caregiver(s), when clinically appropriate, has complete autonomy to elect to participate in services under the 1915(i) benefit.
2. Upon determining that an individual is eligible for the 1915(i) benefit, the individual and/or their caregiver(s), when clinically appropriate, shall be provided a copy of HFS' Individual Rights for Participation Under Illinois' 1915(i) Benefit, to be furnished by HFS or its agent(s).
3. The individual's TPA or CCSO shall engage the individual and their caregiver, when clinically appropriate, secure all necessary consents for participation, and complete all required enrollment documentation. The enrollment documentation shall include the HFS 1915(i) Benefit Provider Selection Form, a listing of all providers in the service areas that offer 1915(i) benefit services, except Care Coordination and Support, for which the individual is eligible.
4. The individual and/or their caregiver, when clinically appropriate, will choose their provider(s) of service from the HFS 1915(i) Benefit Provider Selection Form with the understanding that their selection can be changed at any time, upon their request.
5. For providers that are the only available entity willing and qualified to provide all 1915(i) benefit services in a geographic area, HFS shall require that the entity have sufficient organizational separations and independence between operations (management structures, standard operating procedures, and separation of job functions) to prevent any possible conflict of interest.
6. To further prevent conflict of interest, HFS shall utilize quality of care monitoring activities to ensure fidelity to service delivery practices, including individual choice, person-centered processes for the development of the service plan, individual selection of service providers and preference for service delivery.
7. Finally, HFS will require all providers of 1915(i) Benefit Services to have a written conflict of interest policy detailing, at a minimum, the independence of persons performing evaluations, and service plans by attesting that these persons are not:
    a. Related by blood or marriage to the individual, or any paid caregiver of the individual;
    b. Financially responsible for the individual; or
    c. Empowered to make financial or health-related decisions on behalf of the individual.

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	07/01/2021	06/30/2022	~10,000
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*):
	For Component 1, evaluations are completed by the local community-based behavioral health (CBH) providers and re-evaluations are completed by the CCSO through the Child and Family Team process, described in the Care Coordination and Support service definition below. For Component 2, evaluations and re-evaluations are completed by the TPAs.

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):*

For both Component 1 and 2, individuals performing the evaluation and re-evaluation must meet qualifications consistent with 89 Illinois Administrative Code Section 140.453. The evaluation and re-evaluation must be:

- Organized and completed by staff who minimally meet the qualifications of a Mental Health Professional (MHP); and
- Reviewed and approved by a Licensed Practitioner of the Healing Arts (LPHA).

Component 1. 1915(i) CMH-HCBS: Additional Training Requirements.

All persons performing the evaluation and re-evaluation shall be trained and certified annually by the UP in the usage of the HFS' evaluation instrument. Training requires annual certification testing and the ability to meet a minimum threshold for scoring and interrater reliability.

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:

For Component 1, the initial evaluation process is as follows:

1. An Integrated Assessment and Treatment Plan (IATP) will be completed by a CBH provider of the child's and family's choice.
2. CBH providers are required to submit data on all completed IATPs into HFS' statewide IATP Data Portal, regardless of whether or not the child is seeking access to the 1915(i) benefit.
3. HFS will apply decision support criteria developed by HFS, in collaboration with Dr. John Lyons and the Praed Foundation, to every child's IATP entered through the IATP Data Portal to identify children who are eligible for the 1915(i) benefit.
4. HFS will notify the child and their family of the child's eligibility for the 1915(i) benefit no longer than 45 days after being determined eligible. This notification will include the child's and family's options of CCSO providers for the initiation of 1915(i) service planning.

The re-evaluation process for Component 1 is as follows:

1. CCSOs will re-evaluate the child utilizing the IATP minimally every six months through the Child and Family Team (CFT) process. While the CCSO is the entity responsible for completing the re-evaluation, the consensus of the CFT throughout the re-evaluation process is a requirement of Wraparound (see Care Coordination and Support service definition below) and will be monitored by the UP through a combination of clinical record reviews and IATP data analysis.
2. The CCSO will input the re-evaluated IATP data into the Data Portal.
3. HFS will apply the decisions support criteria to the updated IATP to determine the child's ongoing eligibility for the 1915(i) benefit.

For Component 2, the evaluation and re-evaluation process is as follows:

1. The TPA will complete a thorough clinical evaluation for any individual requesting 1915(i) benefit services that will minimally include the following elements: diagnosis, recent service history and response to treatment, current medication listing, pertinent social history including a review of social determinants of health, clinical summary, history of antisocial/maladaptive risk behaviors and an evaluation of functional impairments. This clinical evaluation may be a combination of clinical interview, clinical record review, and consultation with other service providers.
2. The TPA will evaluate the outcome of the clinical evaluation process against the HCBS needs-based clinical criteria (described below) and will determine if the individual is eligible for the 1915(i) benefit.
3. The TPA will re-evaluate the individual's eligibility for the 1915(i) benefit minimally once every year.
4. Clinical review and monitoring of participant evaluations (representative sample) shall be performed by the UP to ensure TPA adherence to the HCBS needs-based clinical criteria.

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.

Component 1. 1915(i) CMH-HCBS:
In addition to meeting the Target Group Eligibility Criteria, the participant must also meet the following needs-based eligibility criteria:

Have a documented functional impairment on the individual's Integrated Assessment and Treatment Plan (IATP), which substantially interferes with, or substantially limits, the ability to function in the family, school, or community setting.

The IATP will serve as the standardized evaluation for determining eligibility for the 1915(i) benefit. HFS has designated the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) as the approved IATP instrument. The IM+CANS was developed as the result of a collaborative effort between the Illinois Departments of Healthcare and Family Services (HFS), Human Services-Division of Mental Health (DHS-DMH, Illinois' Mental Health Authority), Children and Family Services (DCFS, Illinois's Child Welfare Agency) and Dr. John Lyons. The IM+CANS is a comprehensive assessment that provides a standardized, modular framework for assessing the global needs and strengths of individuals who require mental health treatment in Illinois. The IM+CANS incorporates:

- A complete set of core and modular CANS items addressing domains such as: Risk Behaviors, Trauma Exposure, Behavioral/Emotional Needs, Life Functioning, Substance Use, Developmental Disabilities, and Cultural Factors;
- Adverse Childhood Experiences (ACEs);
- A fully integrated assessment and treatment plan;
- A physical Health Risk Assessment (HRA); and,
- A population-specific addendum for youth involved with the child welfare system.

At the core of the IM+CANS is the Child and Adolescent Needs and Strengths (CANS) and the Adult Needs and Strengths Assessment (ANSA) – communimetric tools containing a set of core and modular items that identify a client's strengths and needs using a '0' to '3' scale.

These items support care planning and decision-making, facilitate quality improvement initiatives, and assist in monitoring the outcomes of services. Additional information on the CANS and ANSA can be found on the Praed Foundation's website: https://praedfoundation.org/.

HFS, in collaboration with Dr. John Lyons (developer of the CANS and ANSA tools), has created decision support criteria to standardize the criteria used to determine the intensity of services and interventions most appropriate to address the child's need. The decision support criteria allow HFS to analyze information from a number of areas including: 1) clinical, 2) social determinants of health, 3) trauma, and 4) other healthcare factors to determine service and intervention intensity. The development of the decision support criteria is based upon Dr. Lyons' international clinical research and findings as well as information gathered from Illinois-specific child population data.

The decision support criteria first considers the treatment/population need by analyzing the identified behavioral/emotional needs of the child, paying particular attention to any concerns related to psychosis and adjustment to trauma, and then considers the functioning needs and risk behaviors of the child. The combination of these factors identifies children who will receive the most benefit from the services included in the 1915(i) benefit.

Component 2.
The following needs-based criteria is applicable, based upon the specific services, as detailed below:

Housing Supports
In addition to meeting the Targeted Eligibility Criteria below, the individual must also meet at least one of the following needs-based eligibility criteria:

- Be at risk of homelessness upon release from settings such as a healthcare facility, residential treatment setting, correctional program, or similar publicly funded congregate setting;
- Demonstrate a functional impairment, including difficulty with basic activities of daily living (ADLs) that are essential for independence; or
- Be at imminent risk of institutional placement.

Supported Employment
In addition to meeting the Targeted Eligibility Criteria below, the individual must also meet the following needs-based eligibility criteria:

- Demonstrate a need for improvement, stabilization, or prevention of deterioration of functioning in the family, home, school, or community (including ability to live independently without support), resulting from the presence of a mental illness or substance use disorder;
- Be expected to benefit from Supported Employment services, which means expressing a desire to work; and
- Have at least one of the following key risk factors:
  - Unable to be gainfully employed for at least 90 consecutive days due to a mental or substance use impairment;
  - More than one instance of inpatient substance use treatment and/or psychiatric hospitalization in the past 2 years;
  - Persistent or chronic risk factors such as social isolation due to a lack of family or social supports, poverty, criminal justice involvement, or homelessness;
  - Care for mental illness and/or substance use disorder requires multiple provider types, including behavioral health, primary care, long-term services and supports, and/or other supportive services;
  - Past psychiatric history, with no significant functional improvement that can be maintained without treatment and/or supports; or
  - Dysfunction in role performance, including one or more of the following:
    1. Behaviors that disrupt employment or schooling, or put employment at risk of termination or schooling suspension;
    2. A history of multiple terminations from work or suspensions/ expulsions from school;
    3. Cannot succeed in a structured work or school setting without additional support or accommodations; and
    4. Performance significantly below expectation for cognitive/ developmental level.

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)
Component 1. 1915(i) CMH-HCBS: The participant must meet the following needs-based eligibility criteria: *Have a documented functional impairment on the individual's Integrated Assessment and Treatment Plan (IATP), which substantially interferes with, or substantially limits, the ability to function in the family, school, or community setting.* The IATP will serve as the standardized evaluation for determining eligibility for the 1915(i) benefit. HFS has designated the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) as the approved IATP instrument. HFS, in collaboration with Dr. John Lyons (developer of the CANS and ANSA tools), has created decision support criteria to standardize the criteria used to determine the intensity of services and interventions most appropriate to address the child's need.	**Persons with Disabilities:** •Under age 60 at time of application •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. •Estimated cost to the State for home care is less than estimated cost for institutional care. •Can be safely maintained in the home or community-based setting with the services provided in the plan of care. **Persons with Brain Injury (BI)** •Persons with brain Injury, of any age, who are at risk of nursing facility placement due to functional limitations resulting from the brain injury. •Have functional limitations directly resulting from an acquired brain injury as documented by a physician or	**Support Waiver for Children and Young Adults with Developmental Disabilities:** •Ages 3 through 21. •Assessed as eligible for an institutional level of care for persons with intellectual disabilities or conditions similar to intellectual disabilities. •Not in need of 24-hour nursing care. **Residential Services for Children and Young Adults with Developmental Disabilities** • Children and young adults with developmental disabilities ages 3 through 21 who are at risk of placement in an Intermediate Care Facility for persons with Developmental Disabilities (ICF/DD). • Ages 3 through 21 • Assessed as eligible for an institutional level of care for persons with intellectual disabilities or conditions similar to intellectual disabilities. • Not in need of 24-hour nursing care. • Must be in need of	**Medically Fragile, Technology Dependent Children Administrative Agency** •Under the age of 21 at time of application •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 •Estimated cost to the State of Illinois is less than estimated cost for institutional care **Hospital** •Eligibility for Hospital LOC is based upon Interqual criteria based on the diagnosis and clinical presentation of the individual requiring hospitalization

Component 2. The following needs-based criteria is applicable, based upon the specific services, as detailed below: **Housing Supports** In addition to meeting the Targeted Eligibility Criteria below, the individual must also meet at least one of the following needs-based eligibility criteria: • Be at risk of homelessness upon release from settings such as a healthcare facility, residential treatment setting, correctional program, or similar publicly funded congregate setting; • Demonstrate a functional impairment, including difficulty with basic activities of daily living (ADLs) that are essential for independence; or • Be at imminent risk of institutional placement. **Supported Employment** In addition to meeting the Targeted Eligibility Criteria below, the individual must also meet the following	neurologist. ○ Includes traumatic brain injury, infection (encephalitis, meningitis), anoxia, stroke, aneurysm, electrical injury, malignant or benign, neoplasm of the brain, and toxic encephalopathy. This does not include degenerative, congenital or neurological disorders related to aging. • Be at risk of nursing facility placement as measured by the Determination of Need (DON) assessment. • Estimated cost to the State for home care is less than estimated cost for institutional care. • Can be safely maintained in the home or community-based setting with the services provided in the plan of care. **Persons who are Elderly** • Target groups are those who are aged, ages 65 and older, and those who are physically disabled, ages 60 through 64. • Be at risk of nursing facility placement as measured by the	children's residential waiver supports. **Adults with Developmental Disabilities** Eligible Population: • Persons age 18 or older with developmental disabilities who are at risk of placement in an Intermediate Care Facility for persons with Developmental Disabilities (ICF/DD). • Age 18 or older • Assessed as eligible for an institutional level of care for persons with intellectual disabilities or conditions similar to intellectual disabilities. • Enrolled in Medicaid, including individuals enrolled through the Health Benefits for Workers with Disabilities (HBWD) program. • Not in need of 24-hour nursing care.	

needs-based eligibility criteria: • Demonstrate a need for improvement, stabilization, or prevention of deterioration of functioning in the family, home, school, or community (including ability to live independently without support), resulting from the presence of a mental illness or substance use disorder; • Be expected to benefit from Supported Employment services, which means expressing a desire to work; and • Have at least one of the following key risk factors: ○ Unable to be gainfully employed for at least 90 consecutive days due to a mental or substance use impairment; ○ More than one instance of inpatient substance use treatment in the past 2 years; ○ Persistent or chronic risk factors such as social isolation due to a lack of family or	Determination of Need (DON) assessment. •Estimated cost to the State for home care is less than estimated cost for institutional care. •Can be safely maintained in the home or community-based setting with the services provided in the plan of care. **Persons with HIV or AIDS** Eligible Population: •Persons of any age who are diagnosed with Human Immune Deficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) and are at risk of placement in a nursing facility •Medical determination of 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. •Estimated cost to the State for home care is less than estimated cost for institutional care. •Can be safely		

social supports, poverty, criminal justice involvement, or homelessness; ○ Care for mental illness and/or substance use disorder requires multiple provider types, including behavioral health, primary care, long-term services and supports, and/or other supportive services; ○ Past psychiatric history, with no significant functional improvement that can be maintained without treatment and/or supports; or ○ Dysfunction in role performance, including one or more of the following: 1. Behaviors that disrupt employment or schooling, or put employment at risk of termination or schooling suspension; 2. A history of multiple terminations from work or suspensions/ expulsions from	maintained in the home or community-based setting with the services provided in the plan of care. **Supportive Living Program** •Persons age 22-64 who have a physical disability (as determined by the Social Security Administration), or persons age 65 or over •Screened by HFS or a designated screening agency, found to be in need of nursing facility level of care and Supportive Living Program is appropriate to meet the person's needs		

school; 3. Cannot succeed in a structured work or school setting without additional support or accommodations; and 4. Performance significantly below expectation for cognitive/ developmental level.			

*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)*):

Component 1. 1915(i) CMH-HCBS: Services will be provided to children meeting the following targeted eligibility criteria. The individual:

1. Is under 21 years of age;
2. Demonstrates a Serious Emotional Disturbance (SED), as defined in 89 ILAC 139.115(e)(1), or has been diagnosed with a Serious and Persistent Mental Illness, based on the most current version of the Diagnostic and Statistical Manual (DSM). The established diagnosis or need cannot be the result of an acute episode, and
3. Meets the established decision support criteria based upon a completed IATP.

Component 2. Housing Supports: Services will be provided to individuals meeting the following targeted eligibility criteria. The individual:

1. Is 17 years of age or older; and
2. Has been diagnosed with a Serious and Persistent Mental Illness or Substance Use Disorder based on the most current version of the Diagnostic and Statistical Manual (DSM), or
3. Has been identified as having two or more chronic conditions as defined in Section 1945(h)(2) of the Social Security Act.

Component 2. Supported Employment: Services will be provided to individuals meeting the following targeted eligibility criteria. The individual:

1. Is age 14 or older; and

2. Has been diagnosed with a Serious and Persistent Mental Illness or Substance Use Disorder based on the most current version of the Diagnostic and Statistical Manual (DSM), or
3. Has been identified as having two or more chronic conditions as defined in Section 1945(h)(2) of the Social Security Act.

☒ **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):

HFS will target 1915(i) State plan HCBS and limit the provision of certain services, defined herein, in the following manner:

Component 1. 1915(i) CMH-HCBS: No limits on enrollment or phase-in of services.

Component 2. Housing Supports:

a. Phase-in of Services: HFS will phase-in the implementation of Housing Support Services beginning on 7/1/2022. This approach allows Illinois Medicaid to launch its Integrated Health Home initiative that will be integral to these services, ensuring that community-based entities operating as HFS qualified Integrated Health Homes may also meet the requirements of the TPA for the purpose of evaluation and service planning for 1915(i) Housing Supports.
b. Enrollment Limits: It is anticipated that demand for 1915(i) Housing Support Services may overwhelm the statewide availability of providers and/or community resources at the time this service launches. To assist with this anticipated demand, HFS will establish training and technical assistance for providers to assist with the service implementation. As a result, HFS will limit the availability of services statewide in the first two years of service implementation in the following manner:

Annual Period	Quarterly Enrollment Targets	Annual Total Targets
Year 2	500 Individuals	2000 Individuals
Year 3	750 Individuals	3000 Individuals

- Quarterly Enrollment Targets shall renew at the start of each quarter, and the state shall not be accountable for meeting annual total targets for this service.
- Quarterly Enrollment Targets shall be provided on a statewide, first come, first enrolled basis.
- Beginning in Year 4 of approved State Plan, the 1915(i) Housing Support Services shall be available statewide with no phase-in or enrollment limits.

Component 2. Supported Employment:

a. Phase-in of Services: HFS will phase-in the implementation of Supported Employment Services beginning on 7/1/2022. This approach allows Illinois Medicaid to launch its Integrated Health Home initiative that will be integral to these services, ensuring that community-based entities operating as HFS qualified Integrated Health Homes may also meet the requirements of the TPA

for the purpose of evaluation and service planning for 1915(i) Supported Employment Services.

b. Enrollment Limits: It is anticipated that demand for 1915(i) Support Employment Services may overwhelm the statewide availability of providers and/or community resources at the time this service launch. To assist with this anticipated demand, HFS will establish training and technical assistance for providers to assist with the service implementation. As a result, HFS will limit the availability of services statewide in the first two years of service implementation in the following manner:

Annual Period	Quarterly Enrollment Targets	Annual Total Targets
Year 2	750 Individuals	3000 Individuals
Year 3	1000 Individuals	4000 Individuals

- Quarterly Enrollment Targets shall renew at the start of each quarter, and the state shall not be accountable for meeting annual total targets for this service.
- Quarterly Enrollment Targets shall be provided on a statewide, first come, first enrolled basis.
- Beginning in Year 4 of the approved State Plan, the 1915(i) Supported Employment Services shall be available statewide with no phase-in or enrollment limits.

(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:

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.)

HFS has established the following procedures and protocols to ensure compliance with the Home and Community-Based Settings requirements, found at 42 CFR 441.301(c)(4)-(5), ensuring that participants receiving 1915(i) benefit services have personal choice and are integrated in, and have full access to, their communities. This includes opportunities to engage in community life, work and attend school in integrated environments, and control one's own personal resources.

Upon enrollment into the 1915(i) benefit, HFS shall verify that the individual's residential address meets the HCBS setting requirements. Any community-based private residence that the participant lives in with the guardian/caregiver, or in the case of those 18 or older living independently in homes, apartments, supported housing, recovery homes, or supervised independent living arrangement, which are located in typical community neighborhoods where people who do not receive home and community-based services reside are presumed to be compliant. Individuals who are homeless, as defined by the McKinney-Vento Act, are presumed to be compliant.

Any type of institutional or institution-like residence as defined by federal regulations would be considered a non-compliant HCBS setting, and disallowed, unless otherwise specified within the HCBS service definition for the purposes of transitioning an individual into a community-based setting.

Additionally, the following actions shall be taken on an annual basis to account for any potential changes in residence among participants receiving 1915(i) benefit services:

Address Verification. For Component 1 and Component 2, the CCSO/TPA shall record and update the individual's permanent physical address during the re-evaluation process. Upon the identification of a change in residence, CCSO/TPA staff shall work with the individual and/or or their caregiver(s) when appropriate, to update their address information with the State. The lack of a permanent physical address for individuals and families experiencing homelessness is not considered a violation of the HCBS settings requirements and shall not exclude individuals who are otherwise eligible from accessing 1915(i) benefit services.

1915(i) Benefit Participation. Throughout the course of 1915(i) benefit participation, the individual's CCSO/ TPA and MCO will continue to monitor the home and community-based settings. Participants and providers shall be required to contact the CCSO/ TPA 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, the CCSO/TPA shall notify HFS of the change of status. HFS will be notified if the participant will be out of the identified setting for more than 14 days.

Remediation. Settings found to be out of compliance by the individual's CCSO, TPA, MCO, or HFS, are subject to remediation, including but not limited to corrective action. Any residential setting suspected to be out of compliance, including individuals out of their identified setting for more than 14 days, shall be reported to the individual's MCO and HFS and the following steps will be undertaken:

1. A site visit will be conducted by the individual's CCSO / TPA;
2. If indicated, a follow-up site visit will be conducted by the UP and findings reported directly to HFS.
3. If remediation is warranted, a remediation plan will be developed, and the provider given time to implement remediation efforts.

Ongoing Compliance and Monitoring of Settings. For Component 1 and 2, HFS shall run 1915(i) benefit participant residence data on a quarterly basis to ensure individuals have not transitioned into a disallowed location of residence while participating in the 1915(i) benefit.

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):*

Component 1 and 2 Requirements.

The Face-to-Face Assessment of needs and capabilities will be performed by: 1) a Mental Health Professionals (MHP – 89 ILAC 140.453) who may gather information; with, 2) the Licensed Practitioners of the Healing Arts (LPHA – 89 ILAC 140.453) reviewing and authorizing the assessment.

Mental Health Professionals (MHP)

Staff, who at a minimum meet the qualifications Mental Health Professionals possessing a bachelor's degree in a human service field, have five years of experience or meet other qualifying credentials defined 89 Illinois Administrative Code Section 140.453, may assist in gathering information to complete the face-to-face assessment.

Licensed Practitioners of the Healing Arts (LPHA)

LPHAs in Illinois include, licensed: physicians, advance practice nurses, clinical psychologists, clinical professional counselors (LCPC), marriage and family therapists (LMFT), and clinical social workers (LCSW).

Component 1. 1915(i) CMH-HCBS: Additional Training Requirements.

All persons working on the face-to-face assessment shall be trained and certified annually by the UP in the usage of HFS' Integrated Assessment and Treatment Planning instrument. Training requires annual certification testing and the ability to meet a clinical threshold for scoring and interrater reliability.

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):*

For Component 1 and 2, consistent with Item 4 of this Section, the Person-Centered Service plan will be developed by: 1) a Mental Health Professional (MHP – 89 ILAC 140.453) who may gather information for the Plan of Care; with 2) the Licensed Practitioners of the Healing Arts (LPHA – 89 ILAC 140.453) reviewing and authorizing the service plan.

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):*

Component 1 and 2 Requirements.

The Mental Health Professional, listed above, working as a care coordinator, shall be responsible for:

a) The dissemination of information to the participant and/or their caregiver(s), when appropriate, regarding: 1) the development of a treatment team; 2) clinical service options, including 1915(i) benefit services; and 3) work done to promote the development of natural supports;

b) Ensuring that all treatment is based upon the individual and family's voice and choice, starting with the face-to-face assessment in which the individual identifies specific needs to address and strengths to build upon in the treatment process. The individual and family's vision for treatment will be utilized by the LPHA, in direct collaboration with the individual and family, to target services and interventions;

c) The individual and family, when clinically appropriate, has the authority to determine who is included in the service plan development process through the choice/ selection of providers which develop the treatment team, and the inclusion of natural supports in the planning process.

Natural Supports: Natural supports refer to the support and assistance individuals receive from being connected to the natural environments such as the family, school, work and community. These connections, and the relationships resulting from these connections, provide direct support and assistance to individuals, in manner that traditional services often fail to address.

Component 1. 1915(i) CMH-HCBS Specific Process.

Individuals and their families participating in Component 1 shall be engaged in a person-centered service plan development process that is based on Wraparound principles and processes. Wraparound adheres to specified procedures for child and family centered engagement, individualized care planning, identifying and leveraging strengths and natural supports.

Through the Wraparound process, children and their families are engaged in determining the participants in their own Child and Family Team (CFT) and are assisted in utilizing a strengths and needs discovery process that identifies their strengths and needs holistically across domains of physical and behavioral health, social services, and natural supports that are then included in the service plan. The CFT is informed about providers of both the 1915(i) benefit and other supportive services in their area and the selection of providers is included in the service plan.

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):*

Component 1 and 2 Requirements.

Individuals and their caregiver(s), when clinically appropriate, shall be offered their choice of available providers of 1915(i) benefit services during service planning. The individual and family's voice and choice of provider shall be captured by the Mental Health Professional, working as a care coordinator, during the service planning phase on a 1915(i) Benefit Provider Selection Form. The Benefit Provider Selection Form shall list all available providers to the individual and family, in alphabetical order, and shall be signed and authorized by the individual and/or caregiver(s), when appropriate, as the final choice in provider.

Component 1 1915(i) CMH-HCBS Specific Process.

Participants eligible for Component 1 CMH-HCBS will receive Care Coordination and Support Services from HFS' selected provider. HFS, in collaboration with its MCOs, shall establish a five (5) year procurement cycle to identify entities meeting the terms of the 1915(i) benefit, inclusive of HFS' Conflict of Interest requirements as described in this application. Selected providers shall be responsible for providing Care Coordination and Support Services for a specific geographical area defined by HFS, ensuring a statewide network of providers willing and qualified to deliver Independent Evaluation, Re-evaluation, and Service Planning. Individuals will be offered their choice of available providers for all other Component 1 CMH-HCBS services consistent with the process described above.

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):*

Component 1. 1915(i) CMH-HCBS: All person-centered service plans shall be submitted by the individual's CCSO to HFS via the IATP Data Portal for the collection of the person-centered service plan. HFS has full access to review all submitted service plans.

Component 2. 1915(i) HCBS: Person-centered service plans shall be submitted to the individual's MCO (enrolled in managed care) or TPA (enrolled in fee-for-service). HFS has full access to review all submitted service plans from either the MCO or the TPA.

Quality Assurance Monitoring: UP shall perform quarterly sampling of independent assessments and person-centered service plans to ensure adherence to federal HCBS rules and regulations. Findings of such quarterly sampling shall 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):*	CCSOs and TPAs			

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:	Care Coordination and Support (CCS)
Service Definition (Scope):	

Care Coordination and Support (CCS) means an evidence-informed, structured approach to care coordination that adheres to required procedures for child and family engagement, individualized care planning, identifying and leveraging strengths and natural supports while monitoring progress and fidelity to the required process. CCS includes a broad set of activities designed to assess, plan, and monitor the service needs of the child and family and includes:

1. Engagement and outreach to children and families, including education on Systems of Care and Wraparound processes;
2. Organization and facilitation of a Child and Family Treatment Team (CFT) that meets on a regular basis;
3. Reviewing and updating the individual's Integrated Assessment and Treatment Plan (IATP), which includes the identification of needs and strengths and the development of a service plan;
4. Crisis Assessment, Safety and Prevention Planning, and Response (CASPR);
5. Coordination and consultation with providers and formal and informal supports involved with the child's care;
6. Referring, linking, and following-up with service providers and social service agencies for services recommended by the CFT on the service plan; and,
7. Assisting children in transitioning from an institutional setting to a community-based living arrangement beginning 60 days prior to discharge from the institutional setting.

CCS services are provided by Care Coordination and Support Organizations (CCSO) that are organized around the Systems of Care philosophy of interagency collaboration, individualized strengths-based care, cultural competence, child and family involvement, community-based services, and accountability. CCSO providers must be immediately available 24 hours a day, 7 days a week, each week of the year to prevent, respond to, de-escalate, and mitigate crisis situations.

CCS shall be provided at two intensity levels – CCS: High Fidelity Wraparound (CCSW) and CCS: Intensive (CCSI):

- CCSW will be delivered in accordance with High Fidelity Wraparound and delivered with a caseload of no more than one care coordinator to every 10 children (1:10). Children receiving CCSW will receive CFT meetings a minimum of every 30 days as well frequent in-person and phone contacts.
- CCSI will be delivered in accordance with Wraparound principles but with less frequent contact requirements with the child and family, as appropriate to stabilize the child's moderate behavioral health needs. CCSI care coordinators will have a caseload of no more than one care coordinator to every 25 children (1:25). Children receiving CCSI will receive CFT meetings a minimum of every 60 days as well frequent in-person and phone contacts.

CCS services are to be provided in a variety of modalities, locations, and times based upon the needs and preferences of the family.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
The decision support criteria based on the child's IATP (described previously) will determine which intensity of care coordination the child will receive.	
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 any individual meeting the eligibility criteria for the Component 1 1915(i) CMH-HCBS with the intensity of the care coordination service based on the decision support criteria described previously. It is anticipated, and expected, that children who are eligible for the 1915(i) benefit will be involved in multiple systems, waivers, and State Plan services, etc., and will receive continued specialized case management from each. For example, the participant involved in the 1915(i) benefit to address behavioral health needs may be in the foster care system and receiving Special Education services. Each of these components offer case management in their areas of expertise and serve an essential role in the individual's care. While the individual may have multiple case managers, the State will develop a process to prevent the duplication of Medicaid funded services and/or duplication of Medicaid payment and may not bill simultaneously for services furnished under any other Medicaid authority (e.g., Targeted Case Management). Services furnished through the 1915(i) benefit must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the individual through these agencies under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the individual's record and kept on file. Additionally, individuals enrolled in CCS services are expected to receive CASPR services in lieu of Mobile Crisis Response (MCR) services, when presenting in crisis in their local community. By ensuring that CASPR services are provided in lieu of MCR, individuals receiving 1915(i) benefit services can ensure that changes in their level of care and immediate crisis needs are responded to by their treatment planning team, increasing service continuity and community stabilization. Moreover, assessment, such as crisis assessment, is one of many forms of case management service that are performed by the CCSO and its staff, in lieu of traditional case management services to ensure no duplication of service occurs with individuals who are eligible for 1915(i) benefit services.
☐	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):*
Care Coordination and Support Organizations	N/A	Providers must be certified as a Community Mental Health Center (59 IAC 132) or a Behavioral Health Clinic (89 IAC 140.499) and must maintain a separate Program Approval on their Medicaid enrollment as a provider of Crisis Services and Care Coordination and Support Services.	Staff delivering CCS services must minimally: • Meet the qualification of an MHP as defined in 89 IAC 140.453; • Have 1 year of experience delivering behavioral health services; • Maintain annual certification in the IATP instrument; • Complete HFS' annual training on crisis services; and • Completed the HFS Wraparound or Intensive Care Coordinator certification process. Supervisors of staff delivering this service must maintain an average supervisor to staff ratio of 1:8 and must minimally: • Meet the qualifications of an QMHP as defined in 89 IAC 140.453; • Have 3 years of experience delivering behavioral health services; • Maintain annual certification in the IATP instrument; • Complete HFS' annual training on crisis services; and • Completed the HFS Wraparound or Intensive Care Coordination Supervisor certification process. Clinical Managers who provide oversight and clinical supervision to Care Coordination Supervisors must minimally: • Meet the qualifications of an LPHA as defined in 89 IAC 140.453; and • Maintain annual certification in the IATP instrument.

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):*
Care Coordination and Support Organizations	HFS in partnership with contracted MCOs.	HFS, in collaboration with its MCOs, shall establish a five (5) year procurement cycle to identify entities meeting the terms of the 1915(i) benefit, inclusive of HFS' Conflict of Interest requirements as described in this application. Selected providers shall be responsible for providing Care Coordination and Support Services for a specific geographical area defined by HFS, ensuring a statewide network of providers willing and qualified to deliver Independent Evaluation, Re-evaluation, and Service planning. HFS will provide annual monitoring of provider quality and adherence to Program Approval requirements.

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: **Family Peer Support**

Service Definition (Scope)*:*

Family Peer Support is defined as a structured, strengths-based, individualized, medically necessary service provided to a parent, legal guardian, or primary caregiver of an individual qualifying for 1915(i) CMH HCBS as detailed above.

Family Peer Support services are directed toward the well-being and benefit of the child. Family Peer Support is designed to enhance the caregiver's capacity to manage the child's behavioral health needs by improving the capacity of the family to understand the child's behavioral health needs, to support the child in the home and community, and to advocate for services and supports for the child and family. Family Peer Support consists of activities that include, but are not limited to, assisting the family to engage in services and supports, assisting the family in self-advocacy, assisting in systems navigation, providing information about the child's behavioral health needs and strengths, identification and building of natural supports, and the promotion of effective family-driven practice.

Family Peer Support must be recommended by an LPHA, in collaboration with the child and family team, and recorded on the Individual Plan of 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 any individual meeting the eligibility criteria for the 1915(i) CMH-HCBS and for whom an LPHA recommends Family Peer Support services on the service plan. Family Peer Support services are to be rendered consistent with frequency, duration, and scope recommended on the service plan. The services provided under Family Peer Support may not be duplicative of other Medicaid Rehabilitation Option or HCBS benefit services. Family Peer Support may be provided, and billed, for meeting with the family in-person, telephonically, or through video communications. Family Peer Support services may not be provided in a group setting. Family Peer Support may not be billed for telephonic communications with other providers or resources.
☐	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):*
Family Peer Support Providers	N/A	Providers must be certified as a Community Mental Health Center (59 IAC 132) or a Behavioral Health Clinic (89 IAC 140.499).	Staff delivering services must minimally: • Meet the qualifications of a Rehabilitative Services Associate (RSA) as defined in 89 IAC 140.453; • Have individual lived experience or experience as a caregiver of a child with special needs, preferably behavioral health needs; • Have experience in navigating any of the child-serving systems; • Have experience in supporting, educating and advocating for family members who are involved with the child-serving systems; • Have access to a Qualified Mental Health Professional (QMHP) or LPHA as defined in 89 IAC 140.453 for clinical consultation; • Complete the HFS Family Peer Support training process; and • Actively participate in ongoing training and coaching by the state or its designee.

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):*

Family Peer Support	HFS	At the time of enrollment and at least every three years

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: **Intensive Home-Based Services**

Service Definition (Scope)*:*

Intensive Home-based Services are face-to-face, individualized, time-limited, focused services provided directly to children and their caregivers in home and community settings to: 1) improve child and family functioning; 2) improve the family's ability to provide effective support for the youth; and 3) promote healthy family functioning. Interventions are designed to enhance and improve the family's capacity to maintain the child within the home and community, and to prevent the child's admission to an inpatient hospital or other out-of-home treatment setting. Intensive Home-Based Services are delivered in two components: Intensive Home-Based Clinical services and Intensive Home-Based Supportive services.

Intensive Home-based Clinical (IHBC) is a strengths-based, individualized, and therapeutic service driven by evidence-informed clinical intervention plan that is focused on symptom reduction. Provision of IHBC services must be consistent with the PracticeWise system guidelines or another HFS approved evidence-based practice.

Intensive Home-based Supports (IHBS) are an adjunct service that may only be provided in conjunction with Home-Based Clinical (IHBC) services. The goal of HBS is to support the child and family in implementing the therapeutic interventions, skills development, and behavioral techniques outlined in the IHBC clinical intervention plan that are consistent with PracticeWise guidelines or another HFS approved evidence-based practice. IHBS services must be provided under the clinical direction of an IHBC clinician, must be recommended by an LPHA, in collaboration with the CFT, and recorded on the service plan.

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):*

	Intensive Home-Based Services will require prior authorization. The initial authorization will cover a period of 60-days for individuals for whom an LPHA has recommended the service on the Individual Plan of Care. Thereafter, services will be authorized in 30-day increments. Intensive Home-Based Services must be provided in the home or the community setting and may include a variety of modalities, including in-person, phone, and videoconference based upon the needs and preferences of the individual. Services are individual-based and family-based in their delivery. Intensive Home-Based Services may not be billed on the same day as Community Support, Assertive Community Treatment (ACT), or Therapy/Counseling to ensure there is no duplication of other services.
☐	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):*
Intensive Home-Based Service Providers	N/A	Providers must be certified as a Community Mental Health Center (59 IAC 132) or a Behavioral Health Clinic (89 IAC 140.499).	IHBC services are delivered by a QMHP or LPHA, as defined in 89 IAC 140.453, who has been certified as a Therapist in PracticeWise system guidelines, or another HFS approved evidence-based practice, and has completed HFS approved training in family therapy or other evidence-based practice approved by HFS. IHBS services are delivered by a MHP, as detailed in 89 ILAC Section 140.453, with a minimum of two years' experience working with children and families and with training in the PracticeWise system guidelines, or another HFS approved evidence-based practice, and has completed HFS-approved training in family therapy or other evidence-based practice approved by HFS. IHBS services must be provided under the clinical direction of an IHBC clinician.

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):*
Intensive Home-Based Service Providers	HFS	At the time of enrollment and at least every three years

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 (Home or Community)**

Service Definition (Scope)*:*

Respite is a time-limited, supervised service that is individualized and provides families scheduled relief to help prevent stressful situations, including avoiding a crisis or escalation within the home. Services shall be provided in the home and in locations within the child's community with the intent of providing both child and caregiver supportive time apart to reduce stress and increase the likelihood of the child remaining safely at home and in the community.

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):*

Respite Services shall not exceed seven (7) hours per event, 21 hours per month, or 200 hours annually without authorization. Respite is not a stand-alone service and must be provided in conjunction with other treatment services. This service must be planned, recommended by an LPHA, in conjunction with the CFT, and documented on the authorized service plan as a needed service. Respite Services 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. Group services shall be limited to sibling groups, not to exceed a 3:1 child to staff ratio.

☐ 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):*
Respite Providers	N/A	Providers must be certified as a Community Mental Health Center (59 IAC 132) or a Behavioral Health Clinic (89 IAC 140.499).	Staff delivering services must minimally: • Meet the qualifications of a Rehabilitative Services Associate (RSA) as defined in 89 IAC 140.453; • Be CPR certified; and, • Have access to a Qualified Mental Health Professional (QMHP) or LPHA as defined in 89 IAC 140.453 for clinical consultation as needed.

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

Provider Type	Entity Responsible for Verification	Frequency of Verification

(Specify):	*(Specify):*	*(Specify):*
Respite Providers	HFS	At the time of enrollment and at least every three years

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 Mentoring**

Service Definition (Scope)*:*

Therapeutic Mentoring is defined as a structured, strengths-developing, individualized, medically necessary service provided to a child, under the age of 21, that present with behavioral health needs and require support in recognizing, displaying, and using pro-social behavior in the home and community setting. Therapeutic Mentoring is designed to assist the individual by improving their ability to navigate various social contexts, observe and practice appropriate behaviors and key interpersonal skills that build confidence, assist with emotional stability, demonstrate empathy, and enhance positive communication of personal needs without escalating into crisis.

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 any individual meeting the eligibility criteria for the 1915(i) CMH-HCBS and for whom an LPHA, in collaboration with the CFT, recommends Therapeutic Mentoring services on the service plan. Therapeutic Mentoring services are to be rendered consistent with frequency, duration, and scope recommended on the service plan. The services provided under Therapeutic Mentoring may not be duplicative of other Medicaid Rehabilitation Option or HCBS benefit services. Therapeutic Mentoring may be provided, and billed, for meeting with the family in-person, telephonically, or through video communications. Therapeutic Mentoring services may not be provided in a group setting.
☐	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):*
Therapeutic Mentoring	N/A	Providers must be certified as a	Staff delivering services must minimally:

Providers		Community Mental Health Center (59 IAC 132) or a Behavioral Health Clinic (89 IAC 140.499).	• Meet the qualifications of an RSA as defined in 89 IAC 140.453; • Have access to a Qualified Mental Health Professional (QMHP) or LPHA as defined in 89 IAC 140.453 for clinical consultation; and • Complete the HFS Therapeutic Mentoring training process.

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):*
Therapeutic Mentoring Providers	HFS	At the time of enrollment and at least every three years

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 Support Services (TSS)**

Service Definition (Scope)*:*

Therapeutic Support Services are adjunct therapeutic modalities to support individualized goals as part of the child's service plan. TSS are designed to help participants find a form of expression beyond words or traditional therapies in an effort to reduce anxiety, aggression, and other clinical issues while enhancing service engagement through direct activity and stimulation. TSS interventions include techniques that can be used for self-expression and personal growth and aid in the healing and therapeutic process.

TSS include, but are not limited to, the following types of interventions:

- Art Behavioral Services
- Dance/Movement Behavioral Services
- Equine-Assisted Behavioral Services
- Horticultural Behavioral Services
- Music Behavioral Services and
- Drama Behavioral Services.

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):*
	Therapeutic Support Services shall not exceed $3000 per state fiscal year per child and are subject to Prior Authorization. The specific TSS interventions must be documented as a recommended service by the authorizing LPHA, in collaboration with the CFT, on the child's service plan. The services provided under TSS may not be duplicative of other Medicaid Rehabilitation Option or HCBS benefit services.
☐	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):*
Therapeutic Support Service Providers	N/A	N/A	To provide a particular Therapeutic Support Service, an individual shall have: (a) A bachelor's or master's degree from an accredited college or university; and (b) demonstration of training or certification specific to the service being rendered. The child's MCO or the TPA will serve as the fiscal agent for this service, authorizing individual services and directly reimbursing qualified providers. The MCO/TPA shall have written policies and procedures to ensure accountability, verify provider qualifications, and ensure that all Therapeutic Support Service are verifiable. The MCO/TPA shall revise its policies as needed and communicate the changes in writing to all parties. The MCO/TPA shall account for all funds used and shall comply with requirements established by HFS.

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):*
Therapeutic Support Service Providers	Fiscal agent (MCO / TPA)	At the time a TSS is approved.

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:	**Individual Supports and Services (ISS)**
Service Definition (Scope)*:*	
Individual Supports and Services are habilitative activities, services and goods that serve as adjunct supports to the therapeutic interventions and supports for children with significant behavioral health issues. ISS are intended to promote health, wellness and behavioral health stability through community stabilization and family stability. ISS services may only be provided for the direct benefit of the child and may not be provided to family members or other collaterals involved with the child's care. ISS may include, but is not limited to, the following categories: • Wellness activities; • Special recreation activities; • Additional aftercare and transition supports not otherwise reimbursable under the Illinois Medical Assistance program; • Sensory items (e.g. weighted blankets, kinetic sand); and • Parent education and training.	
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):*

	Individual Supports shall not exceed $1500 per state fiscal year and are subject to Prior Authorization. The specific ISS interventions must be documented as a recommended service by the authorizing LPHA, in collaboration with the CFT, on the child's service plan and must be directly tied to supporting the achievement of one or more goals on the child's service plan. The services provided under ISS may not be duplicative of other Medicaid Rehabilitation Option or 1915(i) benefit. Unallowable costs include, but are not limited to the following: 1. Organic Organisms (e.g. plants, animals, etc.); 2. Food or Beverages, such as prepared meals or groceries. This does not include services wherein food or beverages are served, but are not the primary focus of the service being provided (e.g. summer camps, after-school programs); 3. Debts, bills, and other financial liabilities of the child or family, including any copayments or coinsurance responsibilities; 4. Rent, mortgage, or other housing-related costs; 5. Experimental or prohibited treatments; 6. Defense and prosecution of criminal and civil proceedings, claims, appeals and patent infringement; 7. Entertainment costs; 8. Gift cards or other cash-equivalent items; 9. Special education costs; 10. Healthcare benefits covered by the Illinois Medical Assistance Program or added benefits covered by the child's MCO; 11. Goods or services that do not have a therapeutic or wellness benefit (e.g. toys, video games, haircuts, cleaning services for the home).
☐	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):*
Individual Support Service Providers	N/A	N/A	The child's MCO or the TPA will serve as the fiscal agent for this service, authorizing individual services and directly reimbursing qualified providers. The MCO/TPA shall have written policies and procedures to ensure accountability, verify provider qualifications, and ensure that all Individual Support Services are verifiable. The MCO/TPA shall revise its policies as needed and communicate the changes in writing to all parties. The MCO/TPA shall account for all funds used and shall comply with requirements established by HFS.

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):*
Individual Support Service Providers	Fiscal agent (MCO / TPA)	At the time an ISS is approved.

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:	**Housing Supports**

Service Definition (Scope)*:*

Housing Supports means a variety of pre-tenancy and tenancy supports provided to individuals with behavioral health and other chronic conditions who are at risk of homelessness or institutional placements without adequate supports. Housing Supports may include any of the following.

Pre-Tenancy Planning and Support. Pre-tenancy Planning and Support services are provided to individuals prior to moving into an independent living arrangement or upon transitioning from one living arrangement to another. Pre-Tenancy Planning and Support includes the following components:

- Person-Centered Assessment. Conduct a community integration assessment identifying the beneficiary's preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual, assistance in budgeting for housing/ living expenses, assistance in obtaining/accessing sources of income necessary for community living, assistance in establishing credit and in understanding and meeting obligations of tenancy).
- Assisting individuals with finding and securing housing as needed. This may include arranging for or providing transportation.
- Assisting individuals in transitioning from an institutional setting to a community-based living arrangement. Transition services may be provided beginning 60 days prior to discharge from the institutional setting.
- Assisting individuals in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings.
- Developing an individualized community integration plan based upon the evaluation as part of the overall Person-Centered Plan. Identify and establish short and long-term measurable goal(s) and establish how goals will be achieved and how concerns will be addressed.

Integrated Tenancy Support. Integrated Tenancy Supports assist the individual in maintaining stable housing in a community-based setting. Integrated Tenancy Supports include:

- Communicating with the landlord or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord or property manager.
- Supporting the individual through dispute resolution with landlord/property manager, as

needed.

- Educating and developing independent living skills as required to retain stable housing.

Fiscal Intermediary Services (FIS). Fiscal Intermediary Services are defined as services that assist the beneficiary, or a representative identified in the beneficiary's service plan, to meet the beneficiary's goals of community participation and integration, independence or productivity. FIS help the individual manage and distribute funds contained in the individual's budget. Fiscal intermediary Services include, but are not limited to:

- Tracking and monitoring participant-directed budget expenditures and identifying potential over- and under-expenditures;
- Education and training on fiscal management; and
- Providing local resources and support for individuals seeking entitlement supports; and
- Ensuring compliance with personal and state-required documentation requirements, as necessary.

The fiscal intermediary may also perform other supportive functions that enable the beneficiary to self-direct needed services and supports. These functions may include selecting, contracting with, or employing and directing providers of services, verification of provider qualifications (including reference and background checks), and assisting the beneficiary to understand billing and documentation requirements.

Enhanced Pharmacy Services (EPS). Enhanced Pharmacy Services are items that are physician-ordered, non-prescription, over-the-counter items as specified in the individual's service plan.

- Medicine management equipment (pill boxes/dose management tools);
- Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies;
- First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads); and
- Other medically necessary items, as ordered by a physician, that is not available via Medicaid or other public funding opportunities.

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):*

	Housing Supports are limited to eight (8) hours per day and a maximum of 200 hours per year. Pre-tenancy supports are limited to 60 hours per 3-month authorization period. Tenancy supports are separately limited to 60 hours per 3-month authorization period. Requests for additional hours required to prevent imminent institutionalization, hospitalization, or out of home/out of community placement require Prior Authorization. Housing Supports are to be rendered consistent with frequency, duration, and scope recommended by an LPHA on the individual's service plan. Housing Supports are not standalone services and must be provided as an adjunct to other community-based treatment services and documented in the individual's service plan. Housing Supports may be provided to the individual in-person, telephonically, or through video communications. Housing Support Services may not be provided in a group setting and may not be duplicated by any other services provided through a Home & Community Based Services 1915(c) waiver. Unallowable services include the following: 1. Payment of rent or other room and board costs; 2. Capital costs related to the development or modification of housing; 3. Expenses for utilities or other regular occurring bills; 4. Goods or services intended for leisure or recreation; and 5. Services to individuals residing in a correctional institution, IMD, or other institutional setting, unless the individual is within 60 days of discharge to a home or community-based setting.
☐	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):*
Housing Support Providers	N/A	Providers must be certified as a Community Mental Health Center (59 IAC 132) or a Behavioral Health Clinic (89 IAC 140.499).	Staff providing this service must minimally meet the following requirements: • Meet the requirements of an RSA as defined in 89 IAC 140.453; • Have two (2) years of clinical experience working in behavioral health or human services, or have completed Mental Health First Aid Training; and • Have knowledge of principles, methods, and procedures of Housing Support services.

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):*
Housing Support	HFS	At the time of enrollment

Providers		and at least every three years

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: **Supported Employment**

Service Definition (Scope)*:*

Supported Employment services are delivered by Employment Navigators who provide individualized, person-centered ongoing supports to individuals age 14 and older who, because of their behavioral health needs, require intensive services to obtain and maintain individual, competitive, integrated employment.

Individual, competitive, integrated employment refers to full or part-time work conducted in a setting in the general workforce where the individual is compensated at or above minimum wage and at a level no less than the customary wages and benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Employment Navigators provide a variety of pre-employment and employment sustaining services that may include, but is not limited to: employment planning, assistance with employer negotiations, transportation, career advancement, job coaching, job analysis, and follow-along supports.

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):*

Supported Employment Services are limited to eight (8) hours per day or a maximum of 200 hours per year. Requests for additional hours required to prevent imminent institutionalization, hospitalization, or out of home/out of community placement require Prior Authorization.

Supported Employment Services are to be rendered consistent with frequency, duration, and scope recommended by an LPHA on the individual's service plan. Supported Employment Services are not standalone services and must be provided as an adjunct to other community-based treatment services and documented in the individual's service plan. Supported Employment Services may be provided to the individual in-person, telephonically, or through video communications. Supported Employment Services may not be provided in a group setting and may not be duplicated by any other services provided through the Home & Community Based Services 1915(c) waiver.

☐ 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):*
Supported Employment Providers	N/A	Providers must be certified as a Community Mental Health Center (59 IAC 132) or a Behavioral Health Clinic (89 IAC 140.499).	Staff providing this service must minimally meet the following requirements: • Meet the requirements of an RSA as defined in 89 IAC 140.453; • Have two (2) years of clinical experience working in behavioral health or human services, or have completed Mental Health First Aid Training; and • Have knowledge of principles, methods, and procedures of Supported Employment services.

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):*
Supported Employment Providers	HFS	At the time of enrollment and at least every three years

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

☐	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. (*Select one):*

●	The state does not offer opportunity for participant-direction of State plan HCBS.
○	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.
○	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):*

○	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.**

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.**

3. **Providers meet required qualifications.**

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).**

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

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

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

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

Discovery Activities					Remediation	
Requirement	Discovery Evidence *(Performance Measures)*	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	Frequency	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Frequency of Analysis and Aggregation
1. Service plans a) address assessed needs of 1915(i) participants;	a) X% of service plans that addressed assessed needs of the individual, based upon the completed	a) Record review of a representative sample of IATP and service plans for participants who were enrolled during the time	a) HFS designee will audit TPA records and the UP will audit CSSO records	a) Every 12 months	a) HFS/MCOs	a), b) and c) If a Corrective Action Plan (CAP) is needed, the CCSO / TPA must submit a CAP within 10 working days to HFS designee or UP. HFS designee

Discovery Activities					Remediation	
Requirement	Discovery Evidence *(Performance Measures)*	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	Frequency	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Frequency of Analysis and Aggregation
	IATP and service plan	period sampled.				or UP will approve the CAP and submit to HFS and MCO, as applicable, within 20 working days. HFS designee or the UP will follow up with the program 90 days after the approval of the CAP. If the CAP has not been implemented (meaning that the program has not come into compliance), HFS designee or UP will report to HFS and MCO who may apply penalties for ongoing non-compliance. HFS designee or UP will provide an annual report of findings with aggregate statistics for overall program performance and recommendations for additional remediation activities.
b) are updated annually; and	b) X% of independent evaluations and service plans for individuals that were reviewed, updated, and completed minimally, every 180 days by the individual's CCSO, or TPA	b) Record review of a representative sample of IATP and service plans for participants who were enrolled during the time period sampled.	b) HFS designee will audit TPA records and the UP will audit CSSO records	b) Every 12 months	b) HFS/MCOs	
c) document choice of services and providers.	c) X% of participant records that include a choice of provider selection form or choice of provider documented on the service plan.	c) Record review of a representative sample of participants who were enrolled during the time period sampled to determine if choice of provider form is in record or service plan contains providers chosen.	c) HFS designee will audit TPA records and the UP will audit CSSO records	c) Every 12 months	c) HFS/MCOs	

Discovery Activities					Remediation	
Requirement	Discovery Evidence *(Performance Measures)*	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	Frequency	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Frequency of Analysis and Aggregation
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;	a) X% of children who had a completed IATP that had the decision support criteria applied to determine their eligibility for Component 1 of the 1915(i); and X% of individuals who requested evaluations for Component 2 of the 1915(i) received them within the required timeframe.	a) Utilization review of a representative sample of children who had a completed IATP during the time period sampled to determine if the decision support criteria was applied to determine their eligibility for Component 1 of the 1915(i); and representative sample of TPA records that indicate a request was received and that an evaluation was completed for Component 2.	a) HFS will complete a utilization review and an external quality review vendor will complete the TPA reviews.	a) Every 12 months	a) HFS	a) For children under Component 1, HFS will compile the utilization review results, identify areas for improvement and implement corrections within 90 days of the compilation of UM results. For individuals under Component 2, if a Corrective Action Plan (CAP) is needed, the TPA must submit a CAP within 10 working days to HFS designee who will approve the CAP and submit to HFS and MCO, as applicable, within 20 working days. HFS designee will follow up with the program 90 days after the approval of the CAP. If the CAP has not been implemented

Discovery Activities					Remediation	
Requirement	Discovery Evidence *(Performance Measures)*	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	Frequency	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Frequency of Analysis and Aggregation
						(meaning that the program has not come into compliance), HFS designee will report to HFS who will apply penalties for ongoing non-compliance. HFS designee will provide an annual report of findings with aggregate statistics for overall program performance and recommendations for additional remediation activities.
(b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and	b) X% of children who had a completed IATP that had the decision support criteria applied and were determined eligible for the 1915(i); and X% of individuals who	b) Record review of a representative sample of children and individuals who were determined to be eligible for the 1915(i) that have documented clinical needs consistent with the 1915(i) eligibility	b) UP will complete the record reviews.	b) Every 12 months	b) UP	b) UP will compile results from the record reviews to determine if the decision support criteria is accurately assigning eligibility for children who meet the eligibility criteria for the 1915(i) and will submit a report of

Discovery Activities					Remediation	
Requirement	Discovery Evidence *(Performance Measures)*	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	Frequency	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Frequency of Analysis and Aggregation
	requested Component 2 of the 1915(i) evaluations and were determined to be eligible for the 1915(i)	criteria.				findings to HFS. HFS will collaborate with the Praed Foundation to adjust the decision support criteria accordingly. For individuals under Component 2, UP will compile results from the record reviews to determine if the evaluation is accurately assigning eligibility for individuals who meet the eligibility criteria and will submit a report of findings to HFS
(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	c) X% of individuals and children who received an annual reevaluation	c) Utilization review of a representative sample of children who were enrolled in the program for over one year to determine if a reevaluation was completed and entered	c) HFS and UP	c) Every 12 months	c) HFS and UP	c) For children, HFS will compile the utilization review results, identify areas for improvement and implement corrections within 90 days of the compilation of UM results. For individuals under

Discovery Activities					Remediation	
Requirement	Discovery Evidence *(Performance Measures)*	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	Frequency	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Frequency of Analysis and Aggregation
		into the IATP portal; and TPA record review of a representative sample of individuals who were enrolled in Component 2 for over one year to determine if a reevaluation was completed.				Component 2, if a Corrective Action Plan (CAP) is needed, the TPA must submit a CAP within 10 working days to UP who will approve the CAP and submit to HFS, within 20 working days. UP will follow up with the program 90 days after the approval of the CAP. If the CAP has not been implemented (meaning that the program has not come into compliance), UP will report to HFS who will apply penalties for ongoing non-compliance. UP will provide an annual report of findings with aggregate statistics for overall program performance and recommendation

Discovery Activities					Remediation	
Requirement	Discovery Evidence *(Performance Measures)*	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	Frequency	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Frequency of Analysis and Aggregation
						s for additional remediation activities.
3. Providers meet required qualifications.	1) % of providers who have submitted claims for 1915(i) services who are approved by HFS.	1) Representative sample of providers who have submitted claims during the time period sampled and who are also approved as 1915i) providers in the HFS Provider Enrollment System	1) HFS	1) Every 12 months	1) HFS	1) Any claims associated with a provider who is not approved as a 1915(i) provider by HFS will be recouped and the provider enrollment will be suspended.
	2) % of providers who continue to meet all provider requirements after a full year of providing services.	2) Review of provider documentation for a representative sample of providers who have been providing 1915i) services for at least a year during the time period sampled to determine if they continue to meet	2) HFS designee and MCOs	2) Every 12 months	2) HFS / MCOs	2) HFS designee and MCOs will conduct provider reviews. Any non-compliance with provider requirements will be documented in a CAP. If a Corrective Action Plan (CAP) is needed, the provider must submit a CAP within 10 working days to

Discovery Activities					Remediation	
Requirement	Discovery Evidence *(Performance Measures)*	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	Frequency	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Frequency of Analysis and Aggregation
		requirements to be an approved provider of 1915i) services.				HFS or MCO. HFS or MCO will approve the CAP and submit to HFS or MCO within 20 working days. HFS or MCO will follow up with the program 90 days after the approval of the CAP. If the CAP has not been implemented (meaning that the provider has not come into compliance), HFS or MCO will apply penalties for the provider's ongoing non-compliance. MCOs and HFS will complete an annual report of findings with aggregate statistics for overall program performance and recommendations for additional remediation activities.
4. Settings	1) % of	1) Annual	1) HFS	1) Every	1) HFS	1) After review

Discovery Activities					Remediation	
Requirement	Discovery Evidence *(Performance Measures)*	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	Frequency	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Frequency of Analysis and Aggregation
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).	individuals who are disenrolled as a result of moving to a setting that is not authorized in this SPA.	review of all enrollees who have been disenrolled during the time period sampled.		12 months		of analysis, if any areas of deficiencies are noted, HFS will develop a performance improvement plan within 30 days.
	2) % of individuals who are enrolled in the 1915i) but have claims submitted from a setting that is not authorized in the SPA	2) Annual review of any institutional claims that have been submitted for a representative sample of enrollees during the time period sampled.	2) HFS	2) Every 12 months	2) HFS	2) After review of analysis, if any areas of deficiencies are noted, HFS will work with MCOs and HFS designee to develop a performance improvement plan within 30 days.
5.The SMA retains authority and responsibility for program operations and oversight	1) % of annual reports submitted to HFS from HFS designee and MCOs	1) Ongoing tracking of required reports that are submitted timely, submitted outside of the timeline or not submitted.	1) HFS	1) Every 12 months	1) HFS	1) – 4) After review of analysis, if any areas of deficiencies are noted, HFS will develop a performance improvement plan within 30 days.
	2) % of required	2) Ongoing tracking of	2) HFS	2) Every 12	2) HFS	

Discovery Activities					Remediation	
Requirement	Discovery Evidence *(Performance Measures)*	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	Frequency	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Frequency of Analysis and Aggregation
	reports submitted to CMS by required timeframes	required reports that are submitted timely, submitted outside of the timeline or not submitted.		months		
	3) % of penalties enforced for non-compliance by 1915i) providers	3) Ongoing tracking of 1915i) provider penalties recommended and penalties enforced.	3) HFS	3) Every 12 months	3) HFS	
	4) HFS directly establishes Medicaid eligibility for enrollee's and has direct oversight of children's 1915i) eligibility	4) HFS continues to maintain eligibility determinations for Medicaid and for children in the 1915i).	4) HFS	4) Ongoing	4) HFS	
6.The SMA maintains financial accountability through payment of claims for services that are authorized	% of HCBS benefit service claims adjudicated appropriately against fund source, authorization	Representative sample of claims paid by HFS or encounters received from MCOs for enrollees during the	HFS	Annually	HFS	After review of analysis, if any areas of deficiencies are noted, HFS will develop a performance improvement plan within 30

Discovery Activities					Remediation	
Requirement	Discovery Evidence *(Performance Measures)*	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	Frequency	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	Frequency of Analysis and Aggregation
and furnished to 1915(i) participants by qualified providers.	history, service limitations, and coding.	timeframe sampled.				days.
7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	1) # of reportable events involving abuse, neglect, and/or exploitation reported that are reported, according to policy 2) % of reportable events involving abuse, neglect, and/or exploitation reported that are resolved, according to policy	1) Tracking of all reported events of abuse, neglect and/or exploitation for any individual enrolled in the 1915i) 2) Resolution tracking for all reported events of abuse, neglect and/or exploitation for any individual enrolled in the 1915i)	1) HFS designee 2) HFS designee	1) Quarterly 2) Quarterly	1) HFS 2) HFS	1) – 2) HFS designee will provide a quarterly report to HFS of all reportable events with both aggregate data and red flags for providers with multiple or serious reports. Multiple and serious reports will be escalated to the proper enforcement agency for follow up.

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

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)

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☒ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used:
(Select one):

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

PRA Disclosure Statement