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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Adults with Developmental Disabilities

C. Waiver Number:IL.0350
Original Base Waiver Number: IL.0350.

D. Amendment Number:IL.0350.R05.01

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

01/01/23

Approved Effective Date: 01/01/23
Approved Effective Date of Waiver being Amended: 07/01/22

2. Purpose(s) of Amendment

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

The purpose of this amendment is to:

1. Update the following appendices:

Main Module:
Brief Waiver Description was updated to add providers must sign the PCP and return to the ISC.

Appendix A:
The Performance Measures have been renumbered to be sequential.

A-6: Assessment Methods and Frequency has been updated to reflect the addition of record reviews in the OA oversight of ISCs.

Appendix B:
B-3-b—updated the Phase-in/Phase-out schedule. An additional 700 unduplicated participants are being added with this amendment, effective January 1, 2023, and effective for Waiver Year 1 to account for the expected increase in waiver membership in response to appropriation. A total of 750 unduplicated recipients were added in Waiver Year 1 because of the impact of phase-in assumptions on the additional 700 members.

B-3-f: Selection of Entrants to the Waiver has been revised to eliminate the separation of residential services and home-based supports and update the priority population criteria. The state does not anticipate any negative impact on current applicants.

Appendix C:
C-1-a—changed “Autism Spectrum Disorder” to “intellectual and developmental disabilities” in the “Other Standard” section for Behavior Consultant to broaden the scope.

C-4— Other Type of Limit has been revised to update how budget limits for home-based supports are determined for 18 to 22 year olds who are still attending school. No customers will experience a reduction or loss of services as a result of this change.

Appendix G:
Performance Measures G2 and G5 were revised to align with IL-0464 and IL-0473;
G-2-a-i—checked the box for restraints being permissible during the delivery of waiver services and added language for restraints;
G-2-a-ii—added language for oversight responsibility;
G-2-b-i—checked the box for restrictive interventions being permissible during the delivery of waiver services and added new language for restrictive interventions;
G-2-b-ii—added language for oversight responsibility.
Quality Improvement- Added Performance Measure G6.

Appendix I:
I-2-a—change in the rate methodology for Residential Habilitation to introduce a Regional Wage Factor; and change in staffing ratios for Supported Employment Small Group Supports, Levels 1 and 2, and rate increases for Adult Day Service, Community Day Services, Emergency Home Response, Occupational Therapy, Physical Therapy, Residential Habilitation, Self-Direction Assistance, Skilled Nursing, Speech Therapy, Supported Employment—Individual, Supported Employment—Group, and 24-hour Stabilization Services.

Appendix J:
J-2-c-i—updates to the Factor D derivation.

2. Correct grammar and punctuation throughout amendment.

3. Clean up language throughout amendment for consistency.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☒ Waiver Application	Main B Optional
☒ Appendix A Waiver Administration and Operation	A-6, Quality Improvement-b: Methods for Remediation
☒ Appendix B Participant Access and Eligibility	B-3-f
☒ Appendix C Participant Services	C-1-a, C-2-a, C-2-b, C-3-a-ii, C-4
☒ Appendix D Participant Centered Service Planning and Delivery	D-1-c, D-2-a, D-2-b-i
☒ Appendix E Participant Direction of Services	E-1-i-i
☒ Appendix F Participant Rights	F-1
☒ Appendix G Participant Safeguards	G-2-a-i, G-2-a-ii, G-2-b-i, G-2-b-ii, Quality Improvement
☐ Appendix H	
☒ Appendix I Financial Accountability	I-2-a
☒ Appendix J Cost-Neutrality Demonstration	J-2-c-i, J-2-d

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

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

  Specify:

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

1. Request Information (1 of 3)

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

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

Adults with Developmental Disabilities

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IL.0350
Waiver Number:IL.0350.R05.01
Draft ID: IL.026.05.01

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

Regular Waiver

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

PRA Disclosure Statement

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

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

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

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

Not applicable.

1. Request Information (3 of 3)

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

Select one:

◉ **Not applicable**

○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

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

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

The OA is the lead agency for community-based services and supports to adults with developmental disabilities. The OA is responsible for eligibility determination, Person-Centered Plan (PCP) development and implementation, enrolling waiver providers, reporting to the MA, and assuring services and providers meet established standards. The MA enrolls providers in Medicaid, provides oversight, consultation and monitoring, processes federal claims and maintains an appeal process.

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

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

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

The waiver affords customers the choice between customer direction, including both budget and employer authority and more traditional service delivery, or a combination of the two options.

The waiver offers a full array of services which include; Adult Day Service, Community Day Service, Residential Habilitation, Occupational Therapy, Physical Therapy, Speech Therapy, Self Direction Assistance, 24-Hour Stabilization Services, Adaptive Equipment, Assistive Technology, Behavior Intervention and Treatment, Behavioral Services (Psychotherapy and Counseling), Emergency Home Response Services, Home Accessibility Modifications, Non-Medical Transportation, Personal Support, Remote Support, Skilled Nursing, Supported Employment – Individual Employment Support, Supported Employment – Small Group Support, Temporary Assistance, Training and Counseling Services for Unpaid Caregivers, and Vehicle Modification.

Customers who choose home-based supports select from a menu of services based on their individual needs within a monthly services cost maximum. When customers exercise employer authority and hire domestic employees, the services of a Financial Management Services (FMS) entity are available. Customers also have a variety of therapies and other services available to them.

ISC staff are trained to educate customers on available providers and assist in making informed choices. Customers are given choices and may receive one or more services. Other services are available through other local and state funding sources and may be included in the PCP in addition to waiver services.

The OA uses all willing and qualified providers for providers seeking certification. OA staff ensure that providers meet all standards being certified and before a contract is issued.

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

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

ISC entities under contract with the OA serve as the local point of access for adults with developmental disabilities.

The MA and the OA maintain separate but complementary processes to monitor customer welfare, service access, and quality. The OA provides the MA with reports of their monitoring activities, including sanctions. The OA responds to the MA's reports

from data obtained in site visits and file reviews conducted by federally approved Quality Improvement Organizations. Negative findings are addressed with corrective actions. The MA and OA meet quarterly to discuss reports that identify problematic trends and track the effects of remediation efforts to improve performance.

An entity called the Developmental Disability Advisory Committee (DDAC) advises the OA on an ongoing basis on reimbursement rates for waiver services, and recommendations regarding issues affecting waiver service delivery. Composition requires representatives from the OA, providers, advocates, stakeholder groups and state agencies. The MA attends all advisory committee meetings and actively participates to clarify Medicaid or waiver policy issues.

3. Components of the Waiver Request

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

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

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

- ( ) **Not Applicable**
- (●) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act

(select one):

- (●) **No**
- ( ) **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver

and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party

(e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

The State solicited public input for this waiver amendment in several ways. The public comment period began 09/09/2022 and concluded on 10/09/2022.

On 09/09/2022 the State Medicaid Agency posted on its public website a draft of the proposed waiver amendment. That link is: http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx.

The non-electronic method of public distribution occurred with postings at Illinois Department of Human Services local offices throughout the state (except in Cook County). In Cook County, the notice was available at the Office of the Director, Illinois Department of Healthcare and Family Services, 401 South Clinton Street, 1st Floor, Chicago, IL. Additionally, a telephone number was provided within the notice to request a paper copy of the proposed waiver amendment. The public notice invited comments via email or regular mail. Finally, the Illinois Department of Human Services, Division of Developmental Disabilities, the operating agency of the HCBS Waiver for Adults with Developmental Disabilities, shared with their stakeholders and other interested parties.

Copies are also available at the following locations:

• Healthcare and Family Services, 201 South Grand Avenue East, Springfield, IL 62763
• Healthcare and Family Services, 401 South Clinton Chicago, IL 60607

The draft waiver amendment will remain on the public website until final approval from CMS.

The State issued tribal notification on 09/09/2022.

The State received the following comments:
(ALL COMMENTS HAVE BEEN ABBREVIATED DUE TO CHARACTER LIMITATIONS)

1) What is the increase stipend for host home CILA consist of in January?
STATE RESPONSE: As stated in the Waiver Amendment: “The Host Family Stipend is determined on resource need and is largely determined using the ICAP. In other words, customers with high needs as determined by the ICAP receive a higher stipend than those with moderate or low needs. Effective 1/1/2023, or upon CMS approval, the stipends range will increase to $80.00/day for a customer with lower needs up to $115.00/day for a customer with higher needs. The Regional Wage Factor applies to this rate. The stipend assumptions are taken from the 2006 Host Family rate methodology, updated for inflation.”"

2) I am concerned regarding the ongoing barriers individuals will experience in accessing occupational therapy (OT). The current process or access to services, authorization of services, service requirements, and updating the Person-Centered Plan (PCP) is burdensome. There are instances when needs can be met through consultation or education, which is currently not an option. Few occupational therapists currently provide waiver-funded services in Illinois. By addressing these concerns, I believe that more occupational therapists will choose to provide services and those practitioners who are already providing these services will be able to provide even greater benefit.
STATE RESPONSE: Thank you for your comment. The DDD will take into consideration for future amendments the current requirements to access Occupational Therapy and the ability for an Occupational Therapist to provide consultation or education services in addition to habilitative supports. The DDD will also consider issuing an Information Bulletin to provide guidance on how to access OT services. Insofar as requiring an update to the PCP, this is a nonnegotiable requirement of the waiver.

3) IARF COMMENTS:
- We support rate components being adjusted annually and reimbursed at the most recent Bureau of Labor Statistics (BLS) median wage. This ensures reimbursement rates for positions remain competitive and a viable reimbursement system is maintained.
- This amendment does not reflect an increase in the vehicle purchase component, as recommended by the Guidehouse Rate Study. We suggest this be included to promote community integration and allow waiver participants to be engaged in their communities.
- Bringing the direct support wage rate reimbursement to 150% of minimum wage will have positive effects on a workforce that is in critically short supply. Expansion of the day services and restructuring rates for providers will allow a wide spectrum of supports. Providing funding for staff 24H/DAY in CILA will ensure supports in their home any time

they are needed. Additionally, funding community day service providers in the Chicago area at the same 15% rate enhancement as CILA ensures funding parody across the I/DD system.
STATE RESPONSE: DDD will take all the above suggestions into consideration.

4) EQUIP FOR EQUALITY COMMENTS:
- We urge the State to remove all nursing caps and the disqualification for people who need 24-hour nursing services.
- We ask the State to cap the size of all future CILAs at four people and to ensure that all CILA residents have freedom in their homes and spend their days in integrated, individualized activities in the community that provide competitive, integrated employment.
- We recommend the State clarify the process for proactive monitoring and use the Ligas monitoring protocol to improve the proactive monitoring process. Finally, we recommend information about the grievance process is widely disseminated Waiver participants/families and ensure ISC providers are fully trained on its provisions.
Response: DDD will take all the above suggestions into consideration.

-We urge the State to include a robust plan for outreach and timely placement of institutionalized people with IDD, including opportunities for individuals to gain a full understanding of community living. The State should also develop a plan to provide HCBS to people who choose them, including creating waiver slots.
STATE RESPONSE: An outreach plan has been implemented through ISC visits to SODCs and ICF/DDs to educate individuals, families, and guardians on waiver services.

Continued in Main B Optional.

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

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

7. Contact Person(s)

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

Last Name: Winsel

First Name: Pamela

Title: Senior Public Service Administrator

Agency: Department of Healthcare and Family Services

Address: 201 South Grand Avenue East - 2nd Floor

Address 2:

City: Springfield, IL

State: **Illinois**

Zip: 62763

Phone: (217) 782-6359 **Ext:** ☐ **TTY**

Fax: (217) 557-8604

E-mail: Pamela.Winsel@ILLINOIS.GOV

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

Last Name: Hedges

First Name: Derek

Title: Public Service Administrator

Agency: Department of Human Services, Division of Developmental Disabilities

Address: 600 East Ash Street, Bldg 400 3rd floor

Address 2:

City: Springfield

State: **Illinois**

Zip: 62703

Phone: (217) 782-5919 **Ext:** ☐ **TTY**

Fax: (217) 782-9444

E-mail: Derek.Hedges@illinois.gov

8. Authorizing Signature

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

Signature: Pam Winsel

State Medicaid Director or Designee

Submission Date: Dec 7, 2022

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

Last Name: Cunningham

First Name: Kelly

Title: Medicaid Administrator

Agency: Healthcare and Family Services

Address: 201 South Grand Ave., East

Address 2:

City: Springfield

State: **Illinois**

Zip: 62626

Phone: (217) 524-7331 **Ext:** ☐ **TTY**

Fax: (217) 782-2570

E-mail: kelly.cunningham@illinois.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

CONTINUED FROM MAIN 6 - REQUIREMENTS:

-We recommend the State include a plan to ensure people with IDD are supported to live in the community. The State should require providers to accept appropriate referrals; make a commitment to stop using SODC placements for Waiver participants in crisis by funding a sufficient number of community-based crisis beds; and develop a plan to rebalance the IDD system, including the closure of SODCs. We also ask that the State eliminate or at least raise the mental health care caps.
STATE RESPONSE: DDD works tirelessly with providers to place individuals in the most appropriate setting. Short Term Stabilization and Support Service Team services are available through the waiver. There are no caps on either of these services. Waiver services are intended to complement behavioral health services available through the State Plan.

-We recommend that the State remove the requirement that a person must successfully complete a DRS Vocational Rehabilitation (VR) program to receive SEI or offer an alternate through which a person could get individual supports. We further recommend removing the 5h/day, 1200 h/yr limit on SEI. Finally, we ask a mechanism to be created for ensuring that people with IDD work in competitive and integrated sites.
STATE RESPONSE: Successful closure from VR indicates a successful outcome in a competitive and integrated job, at which point SEI may be requested.

-We recommend a higher rate of pay for home-based services for those with higher needs, caps are removed from mental health services, the state pay for all mental health services, and there be no limit for intermittent CILA recipients or, at minimum, that the process for getting more than 15 h/wk of Remote Support services be simplified.
STATE RESPONSE: Your recommendation has been shared with the agency with authority over the State Plan services. DDD will review the service limits for waiver services. The base level of 15 h/wk was set in conjunction with the Guidehouse Rate Study. DDD is in the process of simplifying the process for increasing support hours.

-We recommend the State lengthening the 10-day period for an appeal, provide a method for individuals to appeal without an ISC; and to remove the requirement for “re-appealing” in the case of an adverse decision on informal review.
STATE RESPONSE: Timely filing of an appeal is paramount in the process. The 10-day requirement is simply for the individual to indicate they want to appeal. They have 50 days to formalize the appeal paperwork and submit. The individual has to appeal the decision at each level according to their wishes.

CONTINUED FROM APPENDIX G-2-a-i SAFEGUARDS CONCERNING THE USE OF RESTRAINTS:

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

All provider agency employees are required to receive the following:

A) Developmentally appropriate training initially (at hire) and annually thereafter, that shall include, but not be limited to:
1. Crisis de-escalation;
2. Trauma-informed practices;
3. Behavior management practices; and
4. Alternatives to the use of restraint.

B) If the provider agency is utilizing Restraint, the provider agency staff must receive developmentally appropriate training initially (at hire) and annually thereafter, that shall include, but not be limited to:
1. Restraint techniques;
2. Restrictive interventions;
3. Restorative practices; and

4. Identifying signs of distress during restraint.

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

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

CONTINUED FROM APPENDIX I-1:

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

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

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

(c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The MA and OA are responsible for conducting the financial audit program.
The State has several measures in place to ensure that claims describe services rendered. First, errors in billing may be found by the OA or waiver service provider. Second, the MA's claiming system does not allow the OA to submit a claim for a period in which the customer was not active on Medicaid or was active on another HCBS waiver. Further, the OA has implemented systematic checks and internal controls in the billing system, to combat errors and fraud, which verify customer identification and service authorization information. The OA reviews the identified errors and send in a corrective billing through the OA system. The OA system adjusts current and previous remittance as applicable. The OA system then adjusts any previous claiming based on updated provider payments or recoupments.

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

CONTINUED IN MAIN B OPTIONAL UNDER APPENDIX I-2-a
Program Support Costs: Included in the methodologies is a program support component that represents costs that are not direct

care related nor administrative but have an impact on quality. These costs are specific to the program but are not billable, such as quality assurance activities and staff training. The program support percentage is calculated based on direct care cost data reported in the provider survey.

Effective 1/1/23, or upon CMS approval, the Program Support Cost in CILA is set at 5.6% of the Program Component costs, developed from provider cost surveys based on the proportion of reported program support expenses relative to Program Component costs.

Supply Costs: There is a cost center in the methodology called “Other Supplies.” This refers to the costs incurred in the provision of habilitation and training services associated with activities of daily living such as training materials specific to a customer’s Person-Centered Plan (PCP) to assist with increasing skill levels and independence. The methodologies allocate a set allowance of $273.91/per customer/per month for this cost center which is the same allowance in the current CILA rate methodology.

Consultant Services Costs: This cost center provides reimbursement for consultant services that may be necessary to provide or update assessments and develop various therapy plans. The allowance is based on the ICAP score, with customers in the low need range receiving a lower allowance than customers in the high need range.

Nursing Costs: Recognizing the need for customers with developmental disabilities to have regular health care supports and monitoring, reimbursement for 12 hours of LPN and 1 hour of RN supports per year are built into the base reimbursement for all customers receiving CILA residential supports, in all types of CILA settings. Effective 1/1/2023, or upon CMS approval, the OA is changing the base nursing calculation to 18 hours of RN supports for all types of CILA settings. Per the IL Nurse Practice Act (225 ILCS 65/55-30), LPNs can't provide services without RN oversight; therefore, the OA is changing this calculation to fund all RN hours for this support. Base nursing is intended to reimburse providers for the cost associated with the completion of nursing assessments, health risk identification and planning, health supports coordination and implementation, health monitoring and to develop updates to the nursing care plan. Currently, in 1 – 4 person homes, the base nursing is increased to 1 hour of RN and 18 hours of LPN supports per year with additional nursing support hours available as determined by a customer’s Health Risk Screening Tool (HRST) Health Care Level (HCL) score so that a customer can receive up to 77.4 hours of nursing support if warranted by health care level. Effective 1/1/2023, or upon CMS approval, the OA is expanding the HLC multiplier for the nursing components to all 24-hour CILA (1-8 person homes). All nursing supports are adjusted annually and reimbursed at the most recent Bureau of Labor Statistics (BLS) median wage. In addition, there is funding built into the rate to account for RN oversight of medication administration and RN supports for required nursing treatments. The OA is removing the LPN hours for this cost center; therefore, RN oversight will no longer be necessary. The time calculations for medication administration and oversight and treatments are based on the submission of a customer’s Medication Administration Record (MAR) and Treatment Administration Record (TAR). An RN in the OA reviews the MAR and TAR and calculates the staff hours needed for medication administration and treatment oversight.

Administration: The current 24-hour CILA rate methodology incorporates administrative expenses as a fixed cost of $3,666 per year. The Administration reimbursement was derived from the original 24-hour CILA cost of $30,000. At that time, administration costs were set at 10% of the entire CILA rate, or $3,000. The administration cost was converted from a percentage of the CILA Base Residential rate to an annual fixed amount effective July 1, 1999 and has received periodic legislatively mandated COLA adjustments since that time. Based on information received from the provider wage and cost survey, Guidehouse’s resulting analysis as outlined in the Guidehouse Rate Study recommended the administration costs be revised to 15.8% of the Program Component portion of the CILA rate. This represented the median percentage of program costs spent on administrative costs as reported by the providers. The OA will fully implement this recommendation in accordance with the multi-year implementation plan. Currently, Administration costs for all Intermittent CILA types and Host Family CILA are set at 10% of the Program Component portion of the rate. Effective 1/1/2023, or upon CMS approval, the Administrative cost will change from 10% for 24-Hour, Host Family, and Intermittent CILA to the 15.8% recommended by the Guidehouse Rate Study.

Transportation: The transportation component in the 24-hour CILA model is a calculation of two inputs – Vehicle Purchase and Vehicle Operation – divided by the number of individuals living in the home. See Section D.5.3 of the Guidehouse Rate Study for further explanation. The Intermittent CILA rate methodology includes a staff mileage allowance of 50 miles/week, calculated at the 2020 IRS mileage rate. The Host Family CILA rate methodology includes staff mileage allowances for QIDP, Supervisor, Relief & Vacation Staff of 46 miles/week. In addition, the methodology includes a Host Family mileage allowance for ten 7.5-mile trips per week. The mileage allowance will be adjusted annually upon new rates set by the IRS. . Effective 1/1/2023, or upon CMS approval, the mileage portion of the transportation component will increase to the 2022 General Services Administration (GSA) mileage rate of $0.625 per mile.

Regional Wage Factor: Effective 1/1/2023, or upon CMS approval, the OA will be implementing a Regional Wage Factor for all CILA Rate Methodologies. The Regional Wage Factor is part of the Guidehouse Rate Study and is based on an analysis of

reported provider costs, required local minimum wage increases, the consumer price index, and BLS wage data. Guidehouse determined a factor of 15% for the Regional Wage Factor would be necessary to keep pace with higher wage increases in the Chicago metro and collar counties of Illinois. Customers living and receiving CILA services in Chicago and collar counties will have their CILA Rates calculated using increased wage reimbursement and ERE with the Regional Wage Factor.

Rate Components that Differ by CILA Type:

24 Hour CILA
Base staffing costs comprise the largest share of each customer's rate. The reimbursement authorized for this cost center depends on assumptions and internal calculations that model staffing needs each day throughout the week, extrapolated to include the entire year. Assumptions associated with "Time of Day/Day of Week," "Staff to Resident Ratio," as well as substitute staff assumptions are used to calculate the ultimate total reimbursement associated with DSP hours.

Previous to this amendment IL.0350.R05.01, CILA reimbursement for base staffing costs are determined on resource need and is largely determined using the ICAP. In CILA, an individual's ICAP was used to estimate the amount of staffing hours needed throughout the year. Incremental changes in score will increase or reduce those hours and the budgeted costs associated with them. Effective 1/1/2023, or upon the approval of CMS, in addition to the ICAP, the OA is implementing an adjustment factor based on the customer's Health Care Level (HCL) as determined by their Health Risk Screening Tool (HRST). Health Care Level (HCL) is an additional factor in determining the number of DSP hours calculated for a customer in 24-Hour CILA. This factor is incorporating additional DSP time to facilitate customers in getting to and from needed medical appointments. This also implements one of the Guidehouse Rate Study recommendations. Customers with higher HCL Scores will have additional DSP time incorporated into their CILA Rate as a higher HCL score objectively measures and quantifies a customer's health need(s).

Room and Board:
The room and board component is removed from the rate the State claims for federal matching funds. Rates for 24-hour CILA currently include room and board charges. The housing portion of the room and board component is an annual per capita cost by county and CILA home size with adjustments to reflect whether individuals are likely to have their own bedrooms and with a built-in disincentive for larger homes. The housing portion of the room and board costs is based on HUD Fair Market Rent tables and have received periodic increases as funding would allow. The non-housing portion includes reimbursement for such things as utilities and telephone, property and business insurance, maintenance and housekeeping, food supplies and non-food supplies. The annual per capita cost is scaled down for larger homes. The calculated per diem rate is offset by an individual's unearned income, which is collected by the provider.

Occupancy Factor: Providers of 24-hour CILA services bill "present" for days the customer is receiving CILA services and supports at the CILA site and in the community. Providers bill an applicable non-attendance code for any day the customer is not present in the CILA setting or receiving CILA supports for a complete midnight to midnight 24-hour period. The reimbursement for 24- Hour CILA supports is paid on a per-diem basis for days the customer was served. Providers are not paid for non-attendance days. The CILA Rate Methodology for 24-Hour CILA supports assumes a customer is receiving services from the CILA provider 19 hours per day, Monday through Friday, and up to 24 hours per day on weekends, 13 holidays and 10 other days the customer may not attend a day program. The annual funding is averaged for an equal per-diem rate paid to the CILA provider regardless of what day of the week the CILA supports are delivered. Community day services account for the other 5 hours of the day during the week.

Intermittent CILA
The rate methodology for Intermittent CILA is based on billing on an hourly basis.

The Intermittent rate methodology assumes an average of 15 hours of staffing per customer per week as currently determined by the customer's habilitation team and authorized based on customer needs. Reimbursement for base staffing costs are determined on resource need and is largely determined using the ICAP. A customer in need of additional staffing hours may request approval for additional hours by identifying the needs of the customer and documenting the anticipated staff time needed to address the customer's needs.

A Productivity Factor of 20% is used to account for unbillable DSP time. The Productivity Factor percentage follows the logic as specified in the Rate Study for day programs and is factored based on the anticipated percentages of billable and unbillable activities provided by the DSP. Understanding that providers will need to pay staff for unbillable time, the productivity factor is a new and necessary part of the Hourly Intermittent Rate Methodology.
Reimbursement for Supervisor costs assumes 2.5 hours a week as does reimbursement for QIDP costs. The QIDP and Supervisor Wage Rates were established using the 2018 Bureau of Labor Statistics (BLS) median wage. The wages are adjusted annually using the most current BLS median wage and based on the percentage increase received by the DSPs in order to avoid

compression in the wage bands.

Billable Hourly Rates: As not all intermittent services are provided on a 1:1 basis, three different billing codes with three different rates will be available to providers, depending upon the staff intensity of the service being provided. With all the assumptions above, hourly based billing rates effective 1/1/2023, or upon CMS approval, will be:
1:1 staffing -- $50.76/hour statewide and $57.81 in Chicago and collar counties
1:2 staffing -- $25.38/hour statewide and $28.90 in Chicago and collar counties
1:3 or higher staffing -- $16.92/hour statewide and $19.27 in Chicago and collar counties

Customers are automatically authorized for a maximum of 780 hours annually which can be used flexibly throughout the day, week, month, and year as the customer wants, needs and the PCP dictates. There is a process for requesting additional hours as warranted above.

Host Family CILA
The Host Family Stipend is determined on resource need and is largely determined using the ICAP. In other words, customers with high needs as determined by the ICAP receive a higher stipend than those with moderate or low needs. Effective 1/1/2023, or upon CMS approval, the stipends range will increase to $80.00/day for a customer with lower needs up to $115.00/day for a customer with higher needs. The Regional Wage Factor applies to this rate. The stipend assumptions are taken from the 2006 Host Family rate methodology, updated for inflation.

Reimbursement for Supervisor and QIDP costs vary depending on the number of customers served in the Host Family CILA. For 3 - 4 bed CILAs, the methodology assumes 2.5 hours a week for each position and assumes a 1:16 ratio. For 1 – 2 bed CILAs, the methodology increases to 3.22 hours per week for each position and the ratio drops to 1:12. The QIDP and Supervisor ratios are determined by the required monitoring activities for Host Family supports in Illinois Administrative Code Title 59, Chapter 1, Part 115, Section 115.620. The QIDP and Supervisor ratio for 1 and 2 bed Host Family Supports is adjusted for required monitoring activities based on an economy of scale. The QIDP and Supervisor Wage Rates are established using the 2018 Bureau of Labor Statistics (BLS) median wage. The wages are adjusted annually using the most current BLS median wage and increased based on the percentage increase received by the DSPs in order to avoid compression in the wage bands.

Relief Staff Costs: For Host Family CILA, an important program support is billable relief staff to allow the family or live-in caregiver time away from the home. The Host Family rate methodology includes 20 hours per month per person served of relief staff time and 2 weeks of vacation per year. Effective 1/1/2023, or upon CMS approval, relief and vacation staff wages will increase to $17.00/hour with 29.9% ERE. ERE includes legally required benefits such as unemployment taxes, federal insurance contributions and worker’s compensation, paid time off components such as vacation, sick, personal and holiday days and other benefits such as retirement, health insurance and vision and dental insurance. Relief and vacation time are set in rule at Illinois Administrative Code Title 59, Chapter 1, Part 115, Section 115.600. In addition, transportation is funded for the transportation of individuals served to and from community activities and for relief and vacation staff to allow for travel to and from the Host Family site. Transportation allowances for staff (Supervisor, QIDP, and relief and vacation staff) is set at 46 miles/week. Transportation allowance for the Host Family is set at 75 miles/week. Also effective 1/1/2023, or upon CMS approval, all mileage reimbursement will be paid at the 2022 General Services Administration (GSA) mileage rate of $0.625 per mile. The mileage allowance will be adjusted annually upon new rates set by the GSA.

Community Living Facility (CLF) rates are calculated based on past individual provider cost reports. Rates are reviewed based on cost report submissions. Rates are subject to cost of living adjustments when enacted and may be adjusted based on rate appeals. CLFs were not part of the Guidehouse Rate Study. The OA received approval from the Illinois General Assembly to increase CLF rates by 2% effective 1/1/2023, or upon the approval of CMS.

Day Habilitation Services (Community Day Services – On Site, Community Day Services – Off Site, and Enhanced Residential Habilitation).

These rates were originally established July 1, 2006, by the OA and approved by the MA and have been subject to proposed legislative increases in subsequent years. Base compensation for direct service workers forms the foundation of each day habilitation program rate and is equivalent to the statewide DSP hourly wage reimbursement and employee related expenses (ERE) factor of 29.9% for one direct service worker. DSP wages are adjusted when funding is approved by the Illinois General Assembly. The DSP hourly wage reimbursement is currently $16.00 per hour and will increase to $17.00 per hour 01/01/2023, or upon CMS approval.

Community Day Services – On Site is the only day habilitation service that includes capital costs because this is the only day program that requires the use of a facility which incurs reimbursable capital costs. These costs are calculated as the median ratio

of reported annual costs of facilities to the product of clients and annual attendance hours for each facility. Capital costs are set at $1.30 per hour per customer as reported in the provider cost survey.

A staff productivity factor then adjusts the effective hourly compensation to reflect the billable time of a worker assuming five hours of billable time per eight-hour day for each worker. The productivity factor covers employer staff costs for non-billable or other administrative activities. Although DSPs serving as attendants cannot bill specifically for transportation time, the rate methodology for day programs reimburses this time through a productivity-impacted “trips adjustment” that considers the significant non-billable time associated with travel and lunch hours. See Section D.2.2 in the Rate Study. The productivity adjustment, as well as the supervision factor and occupancy adjustments are applied to account for costs of supervisor compensation and for attendance and availability of day program facilities respectively.

The supervision factor reflects the proportion of supervisor compensation, using the wage and ERE assumptions for Lead DSPs, to the ratio of direct service workers to supervisors as reported by each facility. Supervision costs are based on analysis of supervisor span of control in the cost surveys.

Staffing ratios are assumed based on recommendations from the Rates Oversight Committee and finalized in the Guidehouse Rate Study. Assumed ratios for rate development purposes are:

Community Day Services – On Site 1:5
Community Day Services – Off Site 1:4
Enhanced Residential Services 1:3

The occupancy adjustment assumes each facility is open for 260 days annually and is paid for 240 days of attendance by customers annually according to median occupancy information as reported in the cost survey.

Administrative expenses represent the proportion of administrative costs for providing day program services to direct service costs; because direct service costs increase as minimum wage increases, the value for this input should continue to be tied to direct care costs. Administrative overhead factor is set at 18.9% of direct care compensation, developed from provider cost surveys based on the proportion of reported administrative costs to direct care compensation.

Program support costs represents costs that are not direct care related nor administrative but have an impact on quality. These costs are specific to the program but are not billable such as quality assurance activities and staff training. Program support factor is set at 10.6% of direct care compensation, developed from provider cost surveys based on the proportion of reported program support expenses relative to direct care compensation.

Transportations costs: The transportation factor is only part of the Community Day Services – On Site, Community Day Services – Off Site and Enhanced Residential Habilitation Services rates. Base compensation for drivers is the basis of the transportation rate, and because drivers are typically direct service workers, this is equivalent to the statewide minimum hourly wage for one direct service worker. This compensation is then adjusted by the same occupancy factor used for day program calculations.

Transportation-specific cost components include costs relating to the following categories as reported by providers in the provider cost & wage survey, adjusted to the 260-days of operation:
• Materials and Supplies
• Fuel and Lubricants
• Tires
• Insurance
• Utilities
• Technology and Communication Related to Transportation
• Travel and Meetings
• Other Miscellaneous Transportation-Related Expenses
• Passenger Revenue Vehicles
• Service Vehicles
• Other Transportation-Related General Administration Facilities
• Maintenance Personnel
• Vehicle Depreciation
• Property Depreciation
• Capital Leases Amortization
• Land Improvements Amortization
• Purchase Lease Payments

The 18.9% administrative expenses for day program costs hold for the transportation rate and is applied to the total of the adjusted compensation and vehicle and equipment costs listed above. Combining each of these components, including drivers' wages and benefits as well as vehicle-related costs and administrative expenses. See Sections D.1.6 and D.2.2 in the Rate Study. The key component of the transportation add-on is the trips adjustment, which translates the cost of providing transportation via one vehicle to a unit rate by dividing the daily cost by the expected number of trips per day, calculated based on loading and unloading time, number of riders, trip distance, driving speed, and productivity. These components of the trips adjustment are based on reported transportation metrics from the provider cost and wage survey, assumptions about assisting ambulatory and non-ambulatory clients, and policy priorities. Dividing the total daily cost by the trips adjustment and by the number of riders yields a rate per trip per customer.

The rate for Community Day Service will be updated 1/1/2023, or upon CMS approval.

Supported Employment – Individual Employment Support (SEI) and Supported Employment – Small Group Support (SEG) Rate Methodology
These rates were originally established July 1, 2006, by the OA and approved by the MA and have been subject to proposed legislative increases in subsequent years. The rate for both SEI and SEG will be updated 1/1/2023, or upon CMS approval.

Base compensation for job coaches forms the foundation of each supported employment program rate which is a statewide $17.23 hourly wage. The job coach wage is derived from the BLS Occupational Statistics for Illinois in May 2018 and adjusted for inflation to determine the FY22 job coach wage rate assumption of $17.23. The wages are adjusted annually using the most current BLS median wage and increased based on the percentage increase received by the DSPs in order to avoid compression in the wage bands.

Included is an ERE factor of 29.9% for one job coach. Hourly wages determined by BLS Occupational Statistics will be adjusted annually.

Further, adjustments for billable time including the productivity adjustment and days adjustment (equivalent to the concept of an occupancy adjustment in day programs) are different for employment services. Here, the productivity adjustment assumes 6.4 billable hours from an 8-hour day while the days adjustment assumes job coaches can bill each of the 260 service days in a year. The supervision factor is calculated similarly, using differentials between job coaches and job coach supervisors.

The supervision factor reflects the proportion of supervisor compensation, using the wage and ERE assumptions for job coaches, to the ratio of job coaches to supervisors as reported by each provider. Supervision costs are based on analysis of supervisor span of control in the cost surveys. The supervision factor is also adjusted similar to the staff productivity factor using differentials between job coaches and job coach supervisors, adjusting the ratio of the supervisor to supervisee time.

Staffing ratios are assumed based on recommendations from the Rates Oversight Committee. The ratio for SEG Group Levels 1 is being decreased and Level 2 is being increased effective 1/1/2023, or upon CMS approval.
Supported Employment – Individual Employment Support 1:1
Supported Employment – Small Group Supports for SEG Group Level 1 1:3
Supported Employment - small Group Supports for SEG Group Level 2 1:6

Administrative expenses represent the proportion of administrative costs for providing supported employment services to direct service costs; because direct service costs increase as minimum wage increases, the value for this input should continue to be tied to direct care costs. The administrative overhead factor is set at 18.1% of direct care compensation and was developed from provider cost surveys based on the proportion of reported administrative costs to direct care compensation.

Program support costs represents costs that are not direct care related nor administrative but have an impact on quality. These costs are specific to the program but are not billable such as quality assurance activities. The program support factor is set at 10.6% based on the proportion of reported program support expenses relative to direct care compensation.

Transportations costs: Transportation costs are based on anticipated mileage reimbursement for the job coach of 13.5 miles per day at the GSA 2022 Mileage allowance of $0.625 per mile, effective 1/1/2023, or upon CMS approval. The mileage allowance will be adjusted annually upon new rates set by the GSA.

SEI
Rate effective 7/1/2022: $38.30
Rate effective 1/1/2023, or upon the approval of CMS: $40.67

Weighted estimate: $39.49

SEG
Rate effective 7/1/2022: $11.03
Rate effective 1/1/2023, or upon the approval of CMS: $11.71
Weighted estimate: $11.37

Adult Day Service:
Adult Day Service (ADS) is defined as the direct care and supervision of adults in a community-based setting for the purpose of providing personal attention and promoting social, physical, and emotional well-being in a structured setting. ADS providers in this waiver are the same as used by the Illinois Department on Aging (IDoA). They have the same staffing ratios and the same qualifications as the providers used by the IDoA. The ADS rate is based on the rate established by the Illinois Department on Aging (IDoA) in the Elderly waiver (0143). The rate structure in IL-0350 includes ADS transportation in the ADS rate. The ADS rate was originally established by legislation. The ADC rate includes both administrative and direct care costs. Rates are not geographically based and do not include room and board. ADS rates are reviewed minimally every five years by IDoA to ensure the rates are adequate to maintain an ample provider base, quality of services, budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. The ADS rate is being increased effective 1/1/2023 to $19.82 per hour to align with other state agencies who have similar service providers. A study of day service rates was last conducted in 2018, and rates were last increased in 2021. This rate is being increased effective 1/1/2023, or upon the approval of CMS, to align with the rate in IL-0143.

Rate effective 7/1/2022: $12.34
Rate effective 1/1/2023, or upon CMS approval: $19.82
Weighted estimate: $16.10

Personal Support/Temporary Assistance Services
Rates are negotiated between the customer, guardian (as applicable) or representatives and the providers with assistance from the Self Direction Assistance provider. The negotiated rates are specified in the Service Agreement and are subject to review and approval by the OA on either a targeted or sample basis. These rates are not subject to cost of living adjustments.

Home Accessibility and Vehicle Modifications, Adaptive Equipment, Assistive Technology
Rates are usual and customary. Payments are subject to prior approval by the Operating Agency. Two bids are required for approval. Per-customer five-year cost limits and specific cost limits on rental housing governing the use of these services.

Non-medical Transportation
Statewide mileage rates are set by the OA. Per-trip rates are usual and customary charges. The rate is subject to cost of living adjustments when enacted by the General Assembly and signed by the Governor.

Emergency Home Response Services (EHRS)
EHRS is a 24-hour emergency communication link to assistance outside the home for customers with documented health and safety needs and mobility limitations. This service is provided by a two-way voice communication system consisting of a base unit and an activation device worn by the participant that will automatically link the participant to a professionally staffed support center. The statewide rates for installation and monthly basic service are adopted from the rates by the IDoA for their persons who are elderly waiver (IL-0143). The State worked with an external vendor to review its rates to determine if the current rates are efficient, cost effective and allow for the purchase of services at the lowest rate that will ensure access to waiver services by multiple providers. Based upon its analysis, the State increased the Medicaid reimbursement rate for EHRS to $40 for a one-time installation. In developing the rate, the State examined Medicaid reimbursement rates paid in other states, as well as analyzed installation costs incurred by existing contracted and non-contracted providers. The State examined the cost components underlying into the installation activity, which could include administrative costs (completing paperwork, contacting the customer, scheduling an appointment), training and testing (include training the customer to properly use the device and testing the range capacity within the device) and the cost of transportation to the customer's home to perform the installation. Based on this analysis, the State will employ a methodology of frequent, ongoing review to ensure that the installation rate remains in line with similarly situated programs in other states and is reflective of the cost of providing the installation service. The rate for EHRS was last updated in 2019. This rate is being increased effective 1/1/2023, or upon the approval of CMS, to align with the rate in IL-0143.

Rate effective 7/1/2022: $28.00
Rate effective 1/1/2023, or upon CMS approval: $30.00

Weighted estimate: $29.01

Behavior Intervention and Treatment
There are two rate levels for this service based on provider qualifications. The higher rate (Level 1) was based on a weighted combination of Bureau of Labor Statistics wage for licensed clinical psychologists with a doctoral degree, provider survey results, and a comparison to bargaining agreement wages for state employees. The lower rate of 80% rate of the higher rate was based on a weighted combination of Bureau of Labor Statistics wage for a master's degree, provider survey results, and a comparison to bargaining agreement wages for state employees. Both rates are subject to cost of living adjustments when enacted. The rate was last set and reviewed in 2020.

Behavioral Services (Psychotherapy and Counseling) and Skilled Nursing
Rates are based on available cost data for clinical psychologist and social workers on contract with traditional developmental disabilities agencies. The rates are subject to cost of living adjustments when enacted. These services include both individual and group psychotherapy and counseling. The rates for Behavioral Services were last set and reviewed in 2020.
The rate for skilled nursing is based upon the Home Health Agency and Home Nursing Agency Fee Schedule effective 11/1/2019 and updated 2/1/2020. The fee schedule is posted at:
https://www2.illinois.gov/hfs/SiteCollectionDocuments/CopyofHomeHealthFeeScheduleeff11012019rev02042020Final.pdf.

Rate effective 7/1/2022: $39.74
Rate effective 1/1/2023, or upon the approval of CMS: $43.87
Weighted estimate: $41.82

Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy (ST)
These rates are based on rates within the Home Health Fee Schedule [https://www2.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/HHFeeSchedule.aspx]. These rates are increasing to $111 per hour effective 1/1/23, or upon CMS approval. Rate methodologies for Home Health Services under the State Plan are reviewed annually to ensure rates are adequate to maintain an ample provider base and to ensure quality of services. The State completed a review of the OT, PT, and ST rates 12/6/2021.

Rate effective 7/1/2022: $36.00
Rate effective 1/1/2023, or upon CMS approval: $111.00
Weighted estimate: $73.72

Self-Direction Assistance (SDA)
SDA is receiving a 2% Cost of Living Adjustment (COLA) increase effective 1/1/2023, or upon CMS approval, in order to keep pace with the QIDPs in the Independent Service Coordination (ISC) agencies.

Program Component: The Program component of the rate methodology reimburses providers for those costs incurred in providing Self Direction Assistant services. Included in the program component are reimbursement for Qualified Intellectual Disabilities Professional (QIDP) staffing costs, Supervisor staffing costs, and supply costs.

The QIDP and Supervisor Wage Rates are established using the 2018 Bureau of Labor Statistics (BLS) median wage, adjusted to present day. A 28.1% Employment Related Expenses (ERE) factor is calculated on all staff wages. The wages are adjusted annually using the most current BLS median wage and increased based on the percentage increase received by the DSPs in order to avoid compression in the wage bands.

Program Support Costs: Included in the methodology is a program support component that represents costs that are not direct care related nor administrative but have an impact on quality. These costs are specific to the program but are not billable such as quality assurance activities. The program support percentage is calculated based on direct care cost data reported in the provider survey and set at 10.6% of the Program Component costs.

Supply Costs: There is a cost center in the methodology called “Other Supplies.” This refers to the costs incurred in the provision of self-direction and training services associated with activities of daily living such as training materials specific to a customer’s Person-Centered Plan (PCP) to assist with increasing skill levels and independence.

Administration: The SDA rate methodology incorporates administrative expenses as a fixed percentage set at 18.9%. This represents the median percentage of program costs spent on administrative costs as reported by the providers.

A Productivity Factor of 20% is used to account for unbillable staff time. The Productivity Factor is based on the anticipated

percentages of billable and unbillable activities provided by the QIDP. Understanding that providers will need to pay staff for unbillable time, the productivity factor is a necessary part of the SDA Rate Methodology.

Transportation: The transportation component includes a staff mileage allowance of 10 miles/day and is adjusted annually upon new rates set by the GSA.

SDA
Rate effective 7/1/2022: $50.26
Rate effective 1/1/2023, or upon CMS approval: $51.27
Weighted estimate: $50.77

24 Hour Stabilization Services
The rates for this service are initially established through a Request for Applications process. Through this process, the State compares the proposed rates of willing providers. A standard methodology is developed for the waiver service with variation based upon a number of factors defined below. The required components that are used to establish the rate are:
- Direct support staff wages. DSP wages are adjusted when funding is approved by the Illinois General Assembly. The current DSP hourly wage reimbursement is $16.00 per hour and will increase to $17.00 per hour 01/01/2023, or upon CMS approval. Because the DSP staff providing services in 24 Hour Stabilization Services are Registered Behavior Technicians (RBTs), they are given an additional 20% increase over the DSP rate.
- Professional staff wages and clinical contracts, e.g., QIDPs, Behavior Analysts, nurses, etc. The wages are adjusted annually using the most current BLS median wage and increased based on the percentage increase received by the DSPs in order to avoid compression in the wage bands.
- Employment-related expenditures, e.g., employee benefits, FICA, unemployment insurance, workers' compensation, etc. ERE expenditures will be changed to the following percentages: 29.9% for DSP and House Manager staff, 24.9% for RNs, 28.1% for QIDPs, and 21% for all staff not previously mentioned.
- Program-related expenditures, e.g., supervision, supplies, etc. The Program Support Cost is set at 5.6% of the Program Component costs, developed from provider cost surveys based on the proportion of reported program support expenses relative to Program Component costs. The Program Support Cost is effective 1/1/2023, or upon CMS approval.
- Utilization factors
- Administration, e.g., administrative salaries, staff travel, office space and expenses; and
- Transportation of individuals.

The following additional factors may influence the standard methodology and are the basis for rate variations. When all factors are equal, the rates produced by the standard methodology would be the same.

A differential may be included in the rate for the level of expertise and skill of specific professional staff; the differential will again be uniform across all providers.

Regional Wage Factor: Beginning 1/1/2023, or upon CMS approval, the OA will be implementing a Regional Wage Factor for all CILA Rate Methodologies to include the 24 Hour Stabilization Services. The Regional Wage Factor is part of the Guidehouse Rate Study and is based on an analysis of reported provider costs, required local minimum wage increases, the consumer price index and BLS wage data. Guidehouse determined a factor of 15% for the Regional Wage Factor would be necessary to keep pace with higher wage increases in the Chicago metro and collar counties of Illinois. Customers living and receiving CILA services in Chicago and collar counties will have their CILA Rates calculated using increased wage reimbursement and ERE with the Regional Wage Factor.

Once the rates are established, rates may be adjusted through contractual amendments subject to cost of living increases appropriated by the Illinois General Assembly, through negotiations during contract renewals, or through subsequent calls for Request for Applications. The rates for 24-Hour Stabilization Services were last set and reviewed in 2019. The rates were reviewed and updated as of 1/1/2023, or upon CMS approval.

Training and Counseling Services for Unpaid Caregivers
The counseling rate for unpaid care givers is identical to the standard statewide rate currently used in the waiver for participants receiving Individual Counseling services. The rate is based on available cost data for licensed social workers on contract with traditional developmental disabilities agencies. The rate is subject to cost of living adjustments when enacted. The rate was last set and reviewed in 2020.

Reimbursement for training for unpaid care givers is based on usual and customary charges for the tuition or fees to attend the program. Transportation, meals, and lodging to attend training are not included. Reimbursement for training for unpaid care

givers is not subject to cost of living adjustments. The rate was last set and reviewed in 2020.

Remote Support
Equipment: Services are based on the manufacturer's suggested retail price or usual and customary charge defined as: The current retail price of an equipment item that is recommended by the product's manufacturer. If a vendor of equipment is also the manufacturer, the vendor may establish a suggested retail price provided that the price is equal to or less than the suggested retail price or monthly lease amount for the same or a comparable item recommended by one or more other manufacturers.

Two bids are required for approval when purchasing Remote Support Equipment and Ongoing Monitoring from the same vendor. If an individual is unable to obtain two bids, they will submit the single bid along with the explanation why they were unable to obtain a second bid. Valid reasons could include a list of providers they contacted who did not respond, providers they contacted who do not provide coverage in the area they reside, etc. If the reason provided is valid, the request for service will be processed. If the reason is not valid, the OA will follow up with the participant to determine if there is valid rationale for only submitting one bid. Per-individual annual cost limits govern the use of these services.

Ongoing monitoring: Rates are usual and customary. Payments are subject to prior approval by the Operating Agency. Two bids are required for approval and can be taken into account when purchasing Remote Support – Equipment from the same vendor. Per-individual annual cost limits govern the use of these services.

If an individual is unable to obtain two bids, they will submit the single bid along with the explanation why they were unable to obtain a second bid. Valid reasons could include a list of providers they contacted who did not respond, providers they contacted who do not provide coverage in the area they reside, etc. If the reason provided is valid, the request for service will be processed. If the reason is not valid, the OA will follow up with the participant to determine if there is valid rationale for only submitting one bid. Per-individual annual cost limits govern the use of these services.

Appendix A: Waiver Administration and Operation

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

○ **The waiver is operated by the state Medicaid agency.**

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

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

The OA is responsible for determination of customer eligibility, person centered plan (PCP) development, budgeting, enrolling and certifying waiver providers, assuring PCPs are implemented, and that services and providers meet standards established in the approved waiver and governing rules. The MA is responsible for enrolling providers in Medicaid; providing oversight, consultation and monitoring of waiver operations; processing federal claims; and maintaining an appeal process. The MA conducts all waiver appeal hearings and issues final determination decisions. The MA does not delegate this function to the OA. The MA provides independent, trained hearing officers for all appeal hearings. The MA's Waiver Unit reviews and approves all OA rules and policies prior to them being presented to the MA’s Medical Policy Review Committee for final review and approval. The OA consults the MA about all changes in payment rate and methodologies. All changes must be approved by the MA prior to implementation. The MA provides the OA data, reports, or information as may be required to ensure compliance with State and Federal licensure and certification requirements and quality monitoring responsibilities.

The MA and OA both conduct routine oversight monitoring of the fiscal and program activities to assure that the State meets the federal assurances identified in the waiver. The MA contracts with a federally certified Quality Improvement Organization (QIO) to assist the MA in its role of an administrative oversight for the Adults with Developmental Disabilities waiver. The OA’s Bureau of Quality Management conducts their reviews. The OA’s monitoring tools are reviewed annually and approved by the MA prior to implementation.

The MA uses the Raosoft sample size calculator to determine the number of record reviews for both the QIO and OA. The sampling methodology is based on a statistically valid approach that uses a 95% confidence level and a 5% margin of error. The MA selects the customer sample from the Medicaid Management Information System (MMIS) using claims for waiver services in a specific period for the QIO to review.

The QIO conducts record reviews and onsite provider reviews. The onsite provider reviews are more comprehensive than the record reviews. The QIO conducts onsite reviews of eight case management offices each year, with six customers reviewed at each office. The onsite reviews assess how the waiver program operates overall reviewing components of customer eligibility, PCPs, provider qualifications, health and safety, care coordination, and how the system operates and communicates customer needs and issues. Record reviews examine customer eligibility, PCPs, and health and welfare.

The QIO submits a report of findings to the MA at the conclusion of each onsite review and record review. The report consists of a summary of findings for each customer record reviewed, as well as a summary of overall findings detailed by Performance Measure. Remediation activities are tracked by the OA and MA to ensure 100% remediation of findings. Timeframes for completion of remediation will be reported in 30, 60, 90, or greater than 90 days.

Remediation activities will be consistent with the approved activities detailed within each Performance Measure. The MA and OA will work collaboratively to ensure remediation occurs within the required time frames. The QIO then performs remediation validation of all findings at each review site. The OA approves the completed remediation tracking spreadsheet and sends it to the MA.

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

The MA holds quarterly meetings with the OA to review program administration and evaluate system performance. Quarterly meetings also discuss broad topics, onsite reviews, and remediation activities unless circumstances warrant communication prior to these meetings. The agencies also communicate regularly to follow up on issues raised during quarterly meetings. In addition, MA/OA staff communicate regularly regarding any issues that arise relating to administration of the waiver. These topics include general waiver administration, quality improvement strategies, HCBS Rule transition, etc.

Appendix A: Waiver Administration and Operation

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

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

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

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

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

ACES$: Financial Management Services (FMS) are provided by ACES$ contracted through the OA.
ACES$ functions include:

1) Enrolling individually hired Personal Support Workers (PSWs) in IMPACT, the Medicaid provider enrollment system.
2) Conducting background checks.
3) Processing timesheets.
4) Withholding, depositing, and filing taxes.
5) Processing payroll for individually hired PSWs.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

Appendix A: Waiver Administration and Operation

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

The Operating Agency (OA) is responsible for oversight of the ISCs and FMS entities.

The Medicaid Agency (MA) conducts routine monitoring of ISC performance by selecting a statically valid representative sample of customer files. The OA conducts routine monitoring of ISCs and FMS entities by selecting a sample of customer files.

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

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

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

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

As part of the OA's quality oversight and monitoring of the waiver providers, the BQM performs onsite audits of the customer PCPs through Record Reviews. Upon completion of record reviews, the BQM provides a summary of findings by measure and a plan and Waiver specific summary report of findings and recommendations as appropriate. The report includes: Summary of non-compliance related to specific performance measures; Overall summary of record review findings; and recommendations for remediation of non-compliance. The OA follows-up with the agencies to ensure remediation occurs within the required time frames.

The MA contracts with a federally certified Quality Improvement Organization (QIO) to assist the MA in its role of an administrative oversight for the Adults with Developmental Disabilities Waiver. The QIO looks at the provider's staff training documents, the amount of training hours for each staff person, the current licensure's and the results of the background checks. These documents are reviewed as part of onsite Comprehensive Provider Reviews; the QIO visits eight ISCs each year throughout Illinois, with six customers included in each site's sample. Sites and customers are designated by and randomly selected by the MA, respectively.

The MA's ongoing quality monitoring includes sharing of reports from QIO reviews with the OA as well as directly with the review site. Sites are notified of findings and must complete the Remediation Tracking Spreadsheet. If the site scores less than 90% on their overall performance, the OA will request a Corrective Action Plan as well. Review sites must submit the Remediation Tracking Spreadsheet and plan of correction to the OA for its review and any necessary follow up or clarification. The OA must provide a copy of its approval of the Remediation Tracking Spreadsheet to the MA.

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

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

Appendix A: Waiver Administration and Operation

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

The following describes the oversight of the Independent Service Coordination Agencies (ISCs) and FMS entities.

The Medicaid Agency (MA) and the Operating Agency (OA) maintain separate but complementary processes to monitor customer welfare, service access, and quality. The reviews are not conducted concurrently. There is some duplication of review criteria for the MA and OA reviews, but the same criteria are not utilized by the MA and OA.

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

The MA's monitoring activity is not intended to replicate the OA's reviews. The QIO performs two types of onsite reviews: Record Reviews and Comprehensive Provider Reviews. Record reviews are done through the state, based on a randomly drawn representative sample size. As noted above, there are eight Comprehensive Provider Reviews at ISCs with a total of six customers at each site. In addition to the record review, the QIO also conducts two site visits to Community Service Providers and interviews with customers and staff from the ISC and community service provider agencies involved in their care and services.

Oversight of ISCs:

Annually:

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

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

Agencies are notified in writing of any deficiencies and are required to complete the Remediation Tracking Spreadsheet and submit a plan of correction to the OA, including timeframes (for all findings that cannot be corrected immediately while the reviewers are on site), if the agency scores less than 90% on their overall performance. ISC providers must submit the corrective action plan to the OA within 14 calendar days of the exit and are required to develop a plan that will correct all findings, other than those corrected immediately while the reviewers are on site, within 60 calendar days. OA staff review the plan of correction and, if acceptable, approve it.

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

Oversight of an FMS entity(ies):

Annually:

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

The survey protocol includes staff qualifications, training, and background checks as well as personal support worker

(PSW) eligibility and PSW background checks.

The FMS entity is notified in writing of any deficiencies and is required to complete the Remediation Tracking Spreadsheet and submit a plan of correction to the OA, including timeframes (for all findings that cannot be corrected immediately while the reviewers are on site), if the FMS entity scores less than 90% on their overall performance. FMS providers must submit the corrective action plan to the OA within 14 calendar days of the exit and are required to develop a plan that will correct all findings, other than those corrected immediately while the reviewers are on site, within 60 calendar days. OA staff review the plan of correction and, if acceptable, approve it.

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

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

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States

methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Log of Substantive Changes

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MA Meeting Log

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

Data Aggregation and Analysis:

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS

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

	Semi-Annually	

Data Aggregation and Analysis:

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

Performance Measure:
A4 Number and percent of waiver customers receiving services in their home or community that state they are able to participate in meaningful activities that help meet their goals/needs. N: Number of waiver customers receiving services in their home or community that state they are able to participate meaningful activities that help meet their goals/needs. D: Total number of customers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:
A5 Number and percent of waiver customers who state they feel supported in making decisions to remain independent to the greatest extent possible. N: Number of waiver customers who state they feel supported in making decisions to remain independent to the

greatest extent possible. D: Total number of customers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

The Medicaid Agency (MA) will conduct routine programmatic and fiscal monitoring for the Operating Agency (OA).

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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

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

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

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

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

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

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

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

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

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

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☒	**Autism**	18		☒
	☒	**Developmental Disability**	18		☒
	☒	**Intellectual Disability**	18		☒
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

Customers must be assessed as eligible for ICF/IID level of care, must reside within the State of Illinois and not be in need of nursing assessment, monitoring, intervention, and supervision of their condition or needs on a 24-hour basis. The Waiver does not serve customers who need services solely due to physical conditions, but rather serves customers with Intellectual Disabilities or conditions similar to Intellectual Disabilities, thus requiring an ICF/IID level of care.

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

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - ( ) **Other**

    Specify:

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

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount

that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

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

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	25250
Year 2	25859
Year 3	26479
Year 4	27115
Year 5	27766

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)*:

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

Individuals potentially in need of these services are enrolled in the State's PUNS database by one of the contracted entities serving as access points. This database records demographic and clinical information regarding the individual and his/her circumstances, services currently received, and services needed. As appropriations are available, individuals are selected for authorization for waiver services via a process that focuses on the individual's amount of time waiting (after the 18th birthday) in the seeking services category. Entrance to the Waiver for Adults with Developmental Disabilities of otherwise eligible applicants is deferred via this process until capacity becomes available due to turnover or the appropriation of additional funding by the State's legislature.

The intake assessment tool and corresponding PUNS manual have been incorporated into the Independent Service Coordination (ISC) Manual and is available on the Operating Agency's website at: https://www.dhs.state.il.us/page.aspx?item=31201.

The State gives service priority to eligible customers according to the following priority population criteria in priority order, beginning with the most critical need:

1) Individuals who are subject to abuse, neglect, and/or homelessness.
2) Individuals who are youth in care of the Department of Children and Family Services and are approaching the age of 18 and individuals who are aging out of children's residential services funded by the Division of Developmental Disabilities.
3) Individuals who are placed in state-operated developmental centers.
4) Bogard class members as defined in the Bogard Consent Decree and amended Bogard Consent Decree.
5) Individuals registered on DHS' database for Home and Community Based Waiver Services (PUNS).
6) Individuals with Intellectual Disabilities who reside in state-operated mental health hospitals.

The number of customers served each year will be based on available appropriations. New enrollees will be selected from the PUNS database, a database maintained by the OA of individuals potentially in need of state-funded DD services within the next five years.

Appendix B: Participant Access and Eligibility

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

Waiver Phase-In/Phase-Out Schedule
Based on Waiver Proposed Effective Date: 07/01/22

a. The waiver is being (select one):

- (●) **Phased-in**
- ( ) **Phased-out**

b. Phase-In/Phase-Out Time Schedule. *Complete the following table:*

Beginning (base) number of Participants: 22709

Phase-In/Phase-Out Schedule

Waiver Year 1
Unduplicated Number of Participants: 25250

Month	Base Number of Participants	Change	Participant Limit
Jul	22709	745	23454
Aug	23454	46	23500
Sep	23500	47	23547
Oct	23547	47	23594
Nov	23594	46	23640
Dec	23640	47	23687

Waiver Year 2
Unduplicated Number of Participants: 25859

Month	Base Number of Participants	Change	Participant Limit
Jul	23969	48	24017
Aug	24017	47	24064
Sep	24064	47	24111
Oct	24111	48	24159
Nov	24159	48	24207
Dec	24207	48	24255

Phase-In/Phase-Out Schedule

Month	Base Number of Participants	Change	Participant Limit
Jan	23687	47	23734
Feb	23734	47	23781
Mar	23781	47	23828
Apr	23828	47	23875
May	23875	47	23922
Jun	23922	47	23969

Month	Base Number of Participants	Change	Participant Limit
Jan	24255	48	24303
Feb	24303	48	24351
Mar	24351	48	24399
Apr	24399	49	24448
May	24448	48	24496
Jun	24496	48	24544

Waiver Year 3

Month	Base Number of Participants	Change	Participant Limit
Jul	24544	49	24593
Aug	24593	49	24642
Sep	24642	49	24691
Oct	24691	48	24739
Nov	24739	49	24788
Dec	24788	49	24837
Jan	24837	49	24886
Feb	24886	49	24935
Mar	24935	49	24984
Apr	24984	49	25033
May	25033	50	25083
Jun	25083	50	25133

Waiver Year 4

Unduplicated Number of Participants: 27115

Month	Base Number of Participants	Change	Participant Limit
Jul	25133	49	25182
Aug	25182	50	25232
Sep	25232	50	25282
Oct	25282	50	25332
Nov	25332	50	25382
Dec	25382	50	25432
Jan	25432	50	25482
Feb	25482	51	25533
Mar	25533	51	25584
Apr	25584	50	25634
May	25634	51	25685
Jun	25685	51	25736

Waiver Year 5

Unduplicated Number of Participants: 27766

Month	Base Number of Participants	Change	Participant Limit
Jul	25736	51	25787
Aug	25787	51	25838
Sep	25838	51	25889
Oct	25889	51	25940
Nov	25940	52	25992
Dec	25992	51	26043
Jan	26043	51	26094
Feb	26094	52	26146
Mar	26146	52	26198
Apr	26198	52	26250
May	26250	52	26302
Jun	26302	52	26354

c. Waiver Years Subject to Phase-In/Phase-Out Schedule

Year One	Year Two	Year Three	Year Four	Year Five
☒	☒	☒	☒	☒

d. Phase-In/Phase-Out Time Period

	Month	Waiver Year
Waiver Year: First Calendar Month	**Jul**	
Phase-in/Phase-out begins	**Jul**	**1**
Phase-in/Phase-out ends	**Jun**	**5**

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- ○ **§1634 State**
- ○ **SSI Criteria State**
- ◉ **209(b) State**

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

- ◉ **No**
- ○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

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

  Select one:

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

  Specify percentage: ☐

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☒ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

1. Adults age 19 and above without dependent children and with income at or below 138% of the Federal Poverty Level (Adult ACA Population) as provided in Section 1902(a)(10)(A)(i)(VIII)of the Social Security Act (the Act) and Section 42 CFR 435.119 of the federal regulations.

2. Former Foster Care group defined as: young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits and are eligible for services regardless of income and assets pertaining to Title IV-E children under Section 1902(a)(10)(A)(i)(IX)of the Act and Section 42 CFR 435.150 of the federal regulations.

3. Caretaker relatives specified at 42 CFR 435.110.

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

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

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

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

Check each that applies:

☐ **A special income level equal to:**

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

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

Specify dollar amount:

☒ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☒ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-c (209b State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

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

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

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

is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

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

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

The state uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR 435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the state plan**

  (*select one*):

  - ( ) **The following standard under 42 CFR §435.121**

    Specify:

  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - ( ) **The special income level for institutionalized persons**

    (*select one*):

    - ( ) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify percentage:

    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount:

  - (●) **A percentage of the Federal poverty level**

    Specify percentage: 100

  - ( ) **Other standard included under the state Plan**

    Specify:

- ( ) **The following dollar amount**

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

- ( ) **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **The following standard under 42 CFR §435.121**

Specify:

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically

needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

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

Specify:

○ **Other**

Specify:

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

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

Select one:

◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

○ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

- ○ **The special income level for institutionalized persons**
- ◉ **A percentage of the Federal poverty level**

  Specify percentage: 100

- ○ **The following dollar amount:**

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

- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:

- ○ **Other**

  Specify:

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

Select one:

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

  Explanation of difference:

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

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

Select one:

- ◉ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The state does not establish reasonable limits.**
- ○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

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

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

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ◉ **Other**

Specify:

Level of care evaluations and re-evaluations are performed by the Independent Service Coordination (ISC) entities under contract with the Operating Agency. Issues, findings and status of remediation will be shared with the MA on a quarterly basis.

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

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

The ISC agencies employ the QIDPs. Per contractual agreement with the OA, the ISCs are prohibited from providing direct service to waiver customers.

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

All applicants for waiver services are required to have a Pre-Admission Screening and Record Review (PASRR) completed to determine if waiver services are appropriate or institutional care is required.

If waiver services are indicated, an Inventory of Client and Agency Planning (ICAP) is completed. The ICAP is a medical review that consists of a physical examination by a qualified professional, medical history and medication review, and other assessments as needed to determine what service needs are required.

The ICAP gathers information on maladaptive behavior index, adaptive behavior index and service score and level. The psychological assessment gathers information on cognitive/intellectual functioning, developmental history, educational background, adaptive skill level, multi-axial diagnosis that includes a primary diagnosis, and recommendations for future service delivery. The physical assessment gathers information on the individual’s physical condition. The psychiatric assessment gathers information on the individual’s psychiatric history, description of intellectual functioning, memory functioning, orientation, affect, suicidal or homicidal ideation, current attitude, motor behaviors, judgment, thought processes and medication history.

For ongoing redetermination of waiver eligibility, an annual ICAP is required. An evaluation and periodic (at least annual) reevaluations of the customer's need for the level of care provided in an ICF/IID, as defined by 42 CFR 440.150 (1996) is required in Administrative Rule 89. Ill. Adm. Code 120.80.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the**

state Plan.

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The Operating Agency (OA) contracts with Independent Service Coordination (ISC) entities that employ Qualified Intellectual Disabilities Professionals (QIDPs) to complete the level of care evaluations and reevaluations.

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

An evaluation and periodic (at least annual) reevaluation of the customer's need for the level of care provided in an ICF/IID, as defined by 42 CFR 440.150 (1996), is required in Administrative Rule 89. Ill. Adm. Code 120.80.

As part of the initial level of care determination process, staff of the contracted agencies are responsible for performing or arranging for necessary assessments and collecting other needed information to determine level of care. The ISC reviews the assessment results and other available information against the level of care criteria and guidance in the screening manual for developmental disabilities. The ISC uses the totality of the information available and their best clinical judgment in making the determination of eligibility. Assessment information and level of care determinations are documented on forms specified by the OA. Level of care determinations are transmitted electronically to the OA via the Reporting of Community Services (ROCS) system.

The redetermination process is essentially the same as the eligibility process, except the ongoing level of care determination is based on a current ICAP, individual assessments and other information from the personal planning process in conjunction with personal knowledge of the customer. Level of care redeterminations are documented on a form specified by the OA and are transmitted electronically to the OA via the ROCS system.

The OA uses a combination of assessments to determine eligibility, including the ICAP, plus psychological, physical, and psychiatric assessments, as warranted by the individual’s related condition(s). ISC's complete an assessment with the customer using a statewide standardized discovery process developed by the OA with stakeholder input. The ICAP gathers information on maladaptive behavior index, adaptive behavior index and service score and level. The psychological assessment gathers information on cognitive/intellectual functioning, developmental history, educational background, adaptive skill level, multi-axial diagnosis that includes a primary diagnosis, and recommendations for future service delivery. The physical assessment gathers information on the individual’s physical condition that includes a review of the following components: skin, head, eyes and vision, ear and hearing, mouth, neck, lymph nodes, breasts, peripheral circulation, male genitalia and hernias, female genitalia, rectum, musculoskeletal system, and the neurological system. The psychiatric assessment gathers information on the individual’s psychiatric history, description of intellectual functioning, memory functioning, orientation, affect, suicidal or homicidal ideation, current attitude, motor behaviors, judgment, thought processes and medication history. The discovery process collects and compiles information about the customer’s strengths, needs, preferences, desired outcomes, health, and risk factors. The discovery process guides an interview with the customer. Topics covered include the customer’s self-description, communication needs, relationships, living arrangements, work, abilities, health/medication issues, recreation, and community connections. The discovery process is available upon request from the OA.

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

The MA will provide oversight of the OA for monitoring of redeterminations of the Level of Care though two methods:

1. The OA conducts quarterly and annual reviews of the redetermination process. The OA provides this data to the MA and it is available on the OA website for public transparency. The link to the OA’s website is located here: http://www.dhs.state.il.us/page.aspx?item=97777 The MA reviews this data at quarterly waiver meetings. If trends are identified that reveal noncompliance, an action plan would be developed to ensure compliance is achieved.

2. In addition to the OA assessment review and MA oversight, the contracted Quality Improvement Organization reviews a sample of records to ensure compliance. These reports are shared with the Waiver Quality Management team. If noncompliance is identified related to a waiver PM, the Remediation Tracking Spreadsheet is completed. If the noncompliance is not related to a PM, a corrective action plan would be developed to address the issue.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are

conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

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

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**
  Specify the qualifications:

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

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

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

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: Eligibility Report

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Report: Reassessment of Eligibility Report

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
B3: Number and percent of LOC determinations and reevaluations completed for waiver customers using the processes and instruments described in the approved waiver. N: Number of LOC determinations and reevaluations completed for waiver customers using the processes and instruments described in the approved waiver. D: Total number of LOC determinations and reevaluations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Report: MOBUS Report

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

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

Data Aggregation and Analysis:

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

B1:
1. LOC is done/corrected upon discovery
2. If eligible, no additional action
3. If ineligible, correction of billing and claims
4. Individual staff training as appropriate.

Remediation must be completed within 60 days.

B2:
1. LOC is completed upon discovery
2. If eligible, no additional correction required
3. If ineligible, billing and claims adjusted
4. Customer receives assistance with accessing other supports and services.

Remediation must be completed within 60 days.

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

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

The ISC provides the customer/legal representative with additional information and materials on the service options they choose to pursue and arranges for and facilitates conversations with potential service providers including visits to the potential providers as indicated. Upon enrollment and annually thereafter each customer is given a statement of rights by the ISC. Selection of providers is discussed in the statement of rights brochure. The statement of rights can be found at: http://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL462-1201.pdf. The ISCs are trained to educate customers and provide information to the customer on the available providers, their settings if service is to be delivered outside of the home, and to assist customers, if needed in making an informed choice of providers.

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

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

Copies of the IL 462-1238 forms are available in English and Spanish and are maintained by the Independent Service Coordination (ISC) Agency. The OA requires that ISCs adhere to the OA’s standards and policies which require that all written and/or electronic documentation and forms related to all evaluations, reevaluations and customer care are maintained for a minimum period of five years. Active customer records can never be purged regardless of the five-year minimum time-period. ISCs are required to maintain records in a secure, confidential location that is readily accessible during this period. Records are kept securely at the local ISCs or at a secure storage facility until they can be purged by the ISCs.

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Service**		
Statutory Service	**Community Day Services**		
Statutory Service	**Residential Habilitation**		
Extended State Plan Service	**Occupational Therapy (Extended Medicaid State Plan)**		
Extended State Plan Service	**Physical Therapy (Extended Medicaid State Plan)**		
Extended State Plan Service	**Speech Therapy (Extended Medicaid State Plan)**		
Supports for Participant Direction	**Self Direction Assistance**		
Other Service	**24-Hour Stabilization Services**		
Other Service	**Adaptive Equipment**		
Other Service	**Assistive Technology**		
Other Service	**Behavior Intervention and Treatment**		
Other Service	**Behavioral Services (Psychotherapy and Counseling)**		
Other Service	**Emergency Home Response Services (EHRS)**		
Other Service	**Home Accessibility Modifications**		
Other Service	**Non-Medical Transportation**		
Other Service	**Personal Support**		
Other Service	**Remote Support**		
Other Service	**Skilled Nursing**		
Other Service	**Supported Employment - Individual Employment Support**		
Other Service	**Supported Employment – Small Group Supports**		
Other Service	**Temporary Assistance**		
Other Service	**Training and Counseling Services for Unpaid Caregivers**		
Other Service	**Vehicle Modification**		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Service

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Services generally furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the person centered plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the customer. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

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

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

The annual rate is spread over a State fiscal year maximum of 1,200 hours for any combination of day programs. Payment during any month is limited to a maximum of 115 hours for any combination of day programs.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:

Agency

Provider Type:

Community-Based Agencies

Provider Qualifications

License *(specify):*

89 Ill. Adm. Code 240

Certificate *(specify):*

Other Standard *(specify):*

59 Ill. Adm. Code 120
Contract with Department on Aging

Verification of Provider Qualifications

Entity Responsible for Verification:

Department on Aging and Waiver Operating Agency

Department on Aging - Surveys are conducted once per contracting period (three years), with additional surveys conducted as necessary due to complaints or deficiencies.

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Community Day Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

The primary focus of Community Day Services is the acquisition of new skills or maintenance of existing skills based on individualized preferences and goals as outlined in a customer's Person-Centered Plan (PCP). The service shall offer adult skill-building activities, including opportunities for community exploration, inclusion and integration, based upon the customer's current, emerging and newly discovered interests and preferences. The activities shall support the acquisition of new skills as well as support for self-determination, the development of relationships, community integration, employment exploration and/or community contribution (providing for discussion of and general exposure to different types of employment with the goal being to enable the customer to identify and develop interests, cultivate relevant skills, and seek out training). The skill acquisition/maintenance activities should include formal strategies for teaching the individualized skills and include the intended outcome for the customer. Individualized progress for the skill acquisition/maintenance activities should be routinely reviewed and evaluated with revisions made as necessary to promote continued skill acquisition. As the customer develops new skills, his or her training should move along a continuum of habilitation services offered toward greater independence and self-reliance.

CDS is a site-based service with community integration. Community integration must be offered to the customer on a weekly basis at a minimum. Planning for community integrated services should be based on the customer's interests and needs and identified in the customer's PCP.

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

CDS services are aimed at developing activities and/or skills acquisition to support or further integrate community opportunities outside of the customer's home, to foster independence, autonomy or career exploration and encourage the development of a full life in his/her community. Services are typically provided in group settings, but within these settings, customers may receive services as part of a smaller group. If the customer requires individualized services based on the needs identified in the customer's PCP, the customer may receive CDS services on an individualized basis.

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

Activities consist of job exploration activities (not competitive integrated employment) or volunteer work, recreation, educational experiences in natural community settings, maintaining family contacts and purposeful activities and services where persons without disabilities are present.

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

CDS shall support and enhance, rather than supplant, the customer's involvement in public education, postsecondary education/training, individualized competitive integrated employment or self-employment, and services designed to lead to these types of employment.

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

CDS focuses on enabling the customer to attain or maintain his or her maximum functional level and shall be coordinated with any other paid or unpaid services in the customer's PCP. In addition, CDS reinforces skills or lessons taught in other settings.

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

Personal care is a component of day habilitation services when necessary to meet the needs of the customer but shall

not comprise the entirety of the service.
Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

Time spent in transportation between the customer's home and site CDS services will be provided but is not billable because this transportation time is part of the CDS rate. If conducting community integrated CDS activities, the time spent in transportation between community integrated sites where CDS is being conducted is allowed to be billed.

Training and assistance in transportation is provided as needed.

CDS does not include the following:
• Special education and related services (as defined in Section 601 (16) and (17) of the Individuals with Disabilities Education Act) which otherwise are available to the individual through a local education agency;
• Vocational rehabilitation services which otherwise are available to the individual through a program funded under Section 110 of the Rehabilitation Act of 1973.

Activities are expected to increase the customer's opportunity to build connections within his/her local community and provide the following:
• Supports to participate in age-appropriate community activities, groups, associations or clubs to develop social networks;
• Supports to participate in community opportunities related to the development of hobbies or leisure/cultural interests or to promote personal health and wellness (e.g., yoga class, walking group, etc.);
• Supports to participate in adult education and postsecondary education classes;
• Supports to participate in formal/informal associations or community/neighborhood groups;
• Supports to participate in volunteer opportunities;
• Supports to participate in opportunities focused on training and education for self-determination and self-advocacy;
• Supports for learning to navigate the local community, including learning to use public transportation and/or private transportation available in the local area;
• Supports to maintain relationships with members of the broader community (e.g. neighbors, co-workers and other community members who do not have disabilities and who are not paid or unpaid caregivers) through natural opportunities and invitations that may occur.
CDS cannot be provided in the customer's home or during the same time the customer is receiving Residential Habilitation since community integration is part of that service.

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

CDS may be attended Monday through Friday. The annual rate is spread over a State fiscal year maximum of 1,200 hours for any combination of day programs. Monthly payment is limited to a maximum of 115 hours for any combination of day programs. CDS is limited to 5 hours per day.

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

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

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

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Day Services

Provider Category:
Agency
Provider Type:

Special Recreation Associations

Provider Qualifications
License *(specify):*

Certificate *(specify):*

59 Ill. Adm. Code 119

Other Standard *(specify):*

59 Ill. Adm. Code 50
59 Ill. Adm. Code 120
The Provider must have a current contract with the Operating Agency (OA) and meet all contractual requirements.

Verification of Provider Qualifications
Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Annual certification survey

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Day Services

Provider Category:
Agency
Provider Type:

Community-Based Agencies

Provider Qualifications
License *(specify):*

Certificate *(specify):*

59 Ill. Adm. Code 119

Other Standard *(specify):*

59 Ill. Adm. Code 50
59 Ill. Adm. Code 120
The Provider must have a current contract with the Operating Agency (OA) and meet all contractual requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Annual certification survey

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Residential Habilitation is individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. Services are developed in accordance with the needs of the customer and include supports to foster independence and encourage development of a full life in the community, based upon what is important to and for the customer, as documented in his or her Person Centered Plan (PCP). This includes assisting and teaching customers to attain new and maintain and improve existing skills in areas of self-care, daily living, adaptive skills, leisure, and community integration, including building and maintaining relationships.

These supports include adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development to assist the customer to reside in the most integrated setting appropriate to his/her needs and desires.

In addition, Residential Habilitation provides necessary nursing assessment, direction and monitoring by a registered professional nurse, and support services and assistance by a registered professional nurse or a licensed practical nurse to ensure the customer's health and welfare. It also includes administration and/or oversight of the administration of medications consistent with the Illinois Nursing and Advanced Practice Nursing Act (225 ILSC 65) and the Mental Health and Developmental Disabilities Administrative Act. Nursing services are considered an integral part of Residential Habilitation services.

Meeting the routine nursing needs of customers receiving Residential Habilitation is the responsibility of the residential service provider who must employ or contract with a professional nurse to perform their professional duties providing the oversight and training of direct support staff. Nursing supports are part-time and limited; 24-hour nursing supports, similar to those provided in a nursing facility (NF) or Intermediate Care Facility for individuals with Developmental Disabilities (ICF/IID), are not available to customers in the waiver. These services are in addition to any Medicaid State Plan nursing services (or EPSDT nursing, if under 21 years old) for which the customer may qualify.

Residential Habilitation provides personal care and protective oversight and supervision. Residential Habilitation also includes the reduction of maladaptive behaviors through positive behavioral supports and other methods as reviewed and approved by the Human Rights Committee. Payment is not made, directly or indirectly, to members of the customer's immediate family. Transportation provided as a component part of Residential Habilitation is included in the rate paid to providers of Residential Habilitation services.

The Residential Habilitation provider is responsible for developing and carrying out an Implementation Strategy for each customer served. The Implementation Strategy is based on the customer's needs and desires as indicated in his or her PCP. The Strategy documents how, when, where and by whom Residential Habilitation needs and desired outcomes will be met, put into action and addressed.

Some types of Residential Habilitation include payment made for the cost of room and board. Costs covered are building maintenance, upkeep and improvement (other than such costs for modification or adaptations to a residential site required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code). Room & board costs are removed from the rate the State claims for federal match.
The customer and/or the customer's guardian, as applicable, have the right to choose the residential service provider. The residential service provider is responsible for managing the residential habilitation services for the customer based on the customer's PCP. Residential Habilitation services are currently provided in homes of up to eight people.

All Residential Habilitation settings must fully comply with the requirements of the HCBS Setting Rule. Residential Habilitation payments provide the following:
a) All supervision from direct support staff, QIDP, Supervisors and other appropriate staff;
b) All nursing provided in the residence for medication administration oversight, physician ordered protocols and procedures, charting, or other supports as per physician's orders;
c) Transportation (excluding transportation costs associated with other waiver or Medicaid services);
d) Programmatic supplies and fees;
e) Program Support costs. These costs are specific to the program but are not billable such as quality assurance activities;
f) Consultant costs, which provides reimbursement for consultant services that may be necessary to provide or update assessments and develop various therapy plans; and
g) General and Administrative fees for waiver services.

Reimbursement for base staffing costs are determined on resource need and is largely determined using the Inventory for Clinical Assessment and Planning (ICAP). For Residential Habilitation, a customer's score is used to estimate the amount of staffing hours needed throughout the year. Incremental changes in score will increase or reduce those hours and the budgeted costs associated with them.

Types of Residential Habilitation Services:
24-Hour Shift Staff Community Integrated Living Arrangement (24-Hour CILA) - Customers receive a comprehensive individualized array of residential habilitation, individual support services and supports under the direction of a provider support team within the local agency. These homes have on-site shift staff available during all times when customers are present, unless an approved remote supports service is in place that affords a customer more independence or there is a documented safety plan that allows the customer to remain home alone for a specific number of hours per day. Staff provide both scheduled and unscheduled supports and services as needed by customers. This service can be provided in individual and provider owned and controlled settings where one to eight unrelated customers live.

Intermittent Community Integrated Living Arrangement (Intermittent CILA) - A living arrangement provided in a group home, family home, a customer's own home or apartment where eight or fewer unrelated customers with developmental disabilities reside under supervision of a residential provider agency. Customers receive a comprehensive individualized array of residential habilitation, individual support services and supports under the direction of a provider support team within the local agency. This level of support serves customers whose PCP documents they do not require 24-hour and regular on-site staff presence. Intermittent residential services have staff on call 24 hours per day. On-site staff are available to provide both scheduled and unscheduled supports and services as needed by the customers served and as specified in each customer's PCP.

Host Family Community Integrated Living Arrangement (Host Family CILA) – A living arrangement provided in a host family's home. A host family's home can be owned or controlled by the customer receiving services, the host family or a provider agency. Host families consist of one or more persons who are unrelated to the customer with a developmental disability and who are under contract with the provider agency to provide host family services. No more than two customers with developmental disabilities may reside with any single host family (Rule 115.550 a.) unless a waiver is granted according to Rule 115.550 c. Customers receive a comprehensive individualized array of residential habilitation, personal support services and supports under the direction of a provider support team within the local agency.

The two support models are:
a) Standard Host Family level: The residential setting is the full-time residence of the paid care givers. The live-in paid care givers own, lease or rent the residence and provide all necessary support for the customer. The live-in paid care givers arrange relief and vacation staff on their own schedule. Relief and vacation staff are required to be trained and have previously met all DSP hiring requirements.
b) Comprehensive Host Family level: The residential setting may be owned, leased or rented by the customer(s), care givers or provider agency and may house either full or part-time paid care givers. In a Comprehensive Host Family CILA, shift staff employees are regularly scheduled as part of the comprehensive host family staffing and routinely share supervision, care and training responsibilities with the host family care givers, although shift staff never provide more than 50% of needed staff coverage.

Community Living Facility (CLF) – A residential setting licensed by the Department of Public Health that serves customers with developmental disabilities in skills training programs that provide guidance, supervision, training and other assistance, with the goal of eventually assisting these customers in moving to independent living. These programs provide housekeeping, money management, social skills, and community living skills. Customers are encouraged to participate in day activities, such as Community Day Services, Supported Employment, or regular employment. A CLF shall not be a nursing or medical facility and shall house no more than customers, excluding staff, except as provided for in Section 18 of the Community Living Facilities Licensing Act [210 ILCS 35/18]. (Reference: 77 Ill. Adm. Code 370.240) The Department continues to support these programs and vacancies are filled.

Residential Habilitation Rate Modification:
Enhanced Residential Habilitation – Enhanced Residential Habilitation is an enhanced payment option that is authorized when a customer is unable or has chosen not to attend traditional day services. This service is in addition

to other Residential Habilitation services (24-Hour, Intermittent, Host Family, CLF). Because customers receiving this service require or desire supports not able to be met in a traditional day habilitation program, the staffing ratio for this service can be provided at various ratios such as 1:1 but can be up to 1:4, staff to customer. The DDD funds the Enhanced Residential Habilitation at a 1:3 staffing ratio. Enhanced Residential Habilitation may be authorized up to 5 days per week. A customer can participate on a part-time or full-time basis as determined by their needs and as specified in their PCP.

Providers of this service must maintain documentation which supports the billing for the services being provided. The documentation should include start time, stop time, location service was provided, description of service, and outcome. Enhanced Residential Habilitation requires prior approval and must be documented in the customer's PCP. Enhanced Residential Habilitation is authorized when the customer meets at least one of the following criteria:
a) Has an illness or medical condition(s) or severe maladaptive behaviors that prevent participation in a vocational or day habilitation programing;
b) Is over the age of 60 and declines to participate in traditional out of home day habilitation programing;
c) Is unable to locate a traditional community day service program to serve him/her or the community day service program is not appropriate to meet his/her needs; or
d) Has chosen not to participate in traditional day habilitation services on a full or part-time basis.

Reimbursement for base staffing costs are determined on resource need and is largely determined using the Inventory for Clinical Assessment and Planning (ICAP). For Residential Habilitation, a customer's score is used to estimate the amount of staffing hours needed throughout the year. Incremental changes in score will increase or reduce those hours and the budgeted costs associated with them.

Types of Residential Habilitation Services:
24-Hour Shift Staff Community Integrated Living Arrangement (24-Hour CILA) - Customers receive a comprehensive individualized array of residential habilitation, individual support services and supports under the direction of a provider support team within the local agency. These homes have on-site shift staff available during all times when customers are present, unless an approved remote supports service is in place that affords a customer more independence or there is a documented safety plan that allows the customer to remain home alone for a specific number of hours per day. Staff provide both scheduled and unscheduled supports and services as needed by customers. This service can be provided in individual and provider owned and controlled settings where one to eight unrelated customers live.

Intermittent Community Integrated Living Arrangement (Intermittent CILA) - A living arrangement provided in a group home, family home, a customer's own home or apartment where eight or fewer unrelated customers with developmental disabilities reside under supervision of a residential provider agency. Customers receive a comprehensive individualized array of residential habilitation, individual support services and supports under the direction of a provider support team within the local agency. This level of support serves customers whose PCP documents they do not require 24-hour and regular on-site staff presence. Intermittent residential services have staff on call 24 hours per day. On-site staff are available to provide both scheduled and unscheduled supports and services as needed by the customers served and as specified in each customer's PCP.

Host Family Community Integrated Living Arrangement (Host Family CILA) – A living arrangement provided in a host family's home. A host family's home can be owned or controlled by the customer receiving services, the host family or a provider agency. Host families consist of one or more persons who are unrelated to the customer with a developmental disability and who are under contract with the provider agency to provide host family services. No more than two customers with developmental disabilities may reside with any single host family (Rule 115.550 a.) unless a waiver is granted according to Rule 115.550 c. Customers receive a comprehensive individualized array of residential habilitation, personal support services and supports under the direction of a provider support team within the local agency.

The two support models are:
a) Standard Host Family level: The residential setting is the full-time residence of the paid care givers. The live-in paid care givers own, lease or rent the residence and provide all necessary support for the customer. The live-in paid care givers arrange relief and vacation staff on their own schedule. Relief and vacation staff are required to be trained and have previously met all DSP hiring requirements.
b) Comprehensive Host Family level: The residential setting may be owned, leased or rented by the customer(s), care givers or provider agency and may house either full or part-time paid care givers. In a Comprehensive Host Family CILA, shift staff employees are regularly scheduled as part of the comprehensive host family staffing and routinely share supervision, care and training responsibilities with the host family care givers, although shift staff never provide more than 50% of needed staff coverage.

Community Living Facility (CLF) – A residential setting licensed by the Department of Public Health that serves customers with developmental disabilities in skills training programs that provide guidance, supervision, training and other assistance, with the goal of eventually assisting these customers in moving to independent living. These programs provide housekeeping, money management, social skills, and community living skills. Customers are encouraged to participate in day activities, such as Community Day Services, Supported Employment, or regular employment. A CLF shall not be a nursing or medical facility and shall house no more than customers, excluding staff, except as provided for in Section 18 of the Community Living Facilities Licensing Act [210 ILCS 35/18]. (Reference: 77 Ill. Adm. Code 370.240) The Department continues to support these programs and vacancies are filled.

Residential Habilitation Rate Modification:
Enhanced Residential Habilitation – Enhanced Residential Habilitation is an enhanced payment option that is authorized when a customer is unable or has chosen not to attend traditional day services. This service is in addition

to other Residential Habilitation services (24-Hour, Intermittent, Host Family, CLF). Because customers receiving this service require or desire supports not able to be met in a traditional day habilitation program, the staffing ratio for this service can be provided at various ratios such as 1:1 but can be up to 1:4, staff to customer. The DDD funds the Enhanced Residential Habilitation at a 1:3 staffing ratio. Enhanced Residential Habilitation may be authorized up to 5 days per week. A customer can participate on a part-time or full-time basis as determined by their needs and as specified in their PCP.

Providers of this service must maintain documentation which supports the billing for the services being provided. The documentation should include start time, stop time, location service was provided, description of service, and outcome. Enhanced Residential Habilitation requires prior approval and must be documented in the customer's PCP. Enhanced Residential Habilitation is authorized when the customer meets at least one of the following criteria:
a) Has an illness or medical condition(s) or severe maladaptive behaviors that prevent participation in a vocational or day habilitation programing;
b) Is over the age of 60 and declines to participate in traditional out of home day habilitation programing;
c) Is unable to locate a traditional community day service program to serve him/her or the community day service program is not appropriate to meet his/her needs; or
d) Has chosen not to participate in traditional day habilitation services on a full or part-time basis.

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

Enhanced Residential Habilitation in combination with Adult Day Care, Community Day Services, Supported Employment – Individual Employment Support, and Supported Employment – Small Group Supports cannot exceed 1,200 hours per year, 115 hours a month, and 5 hours a day.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:

Community-Based agencies (CLF)

Provider Qualifications
License *(specify):*

77 Ill. Adm. Code 370

Certificate *(specify):*

Other Standard *(specify):*

59 Ill. Adm. Code 120
59 Ill. Adm. Code 116

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Public Health

Frequency of Verification:

Annual surveys and ongoing complaint investigations

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:

Agency

Provider Type:

Community-Based Agencies (CILA)

Provider Qualifications

License *(specify):*

59 Ill. Adm. Code 115

Certificate *(specify):*

Other Standard *(specify):*

59 Ill. Adm. Code 50
59 Ill. Adm. Code 120
59 Ill. Adm. Code 116
The Provider must have a current contract with the Operating Agency (OA) and meet all contractual requirements

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy (Extended Medicaid State Plan)

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

Services are subject to prior approval by the OA.

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy (Extended Medicaid State Plan)

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

225 ILCS 75/1 et seq.
68 Ill. Adm. Code 1315

Certificate *(specify):*

Other Standard *(specify):*

Occupational Therapist may directly supervise a Certified Occupational Therapist Assistant

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency and Medicaid Agency

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy (Extended Medicaid State Plan)

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

Services are subject to prior approval by the Operating Agency.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Physical Therapist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy (Extended Medicaid State Plan)

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Physical Therapist may directly supervise a Certified Physical Therapy Assistant.

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Speech Therapy (Extended Medicaid State Plan)

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

Services are subject to prior approval by the Operating Agency.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Speech/Language Pathologist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech Therapy (Extended Medicaid State Plan)

Provider Category:

Individual

Provider Type:

Speech/Language Pathologist

Provider Qualifications

License *(specify):*

225 ILCS 110/1 et seq.
68 Ill. Adm. Code 1465

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Self Direction Assistance

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 2:	**Sub-Category 2:**

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

Service Definition *(Scope)*:

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

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

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

This service can't be used to replace other waiver services such as Personal Support, Temporary Assistance and Non-Medical Transportation. Additionally, this service can't be used to replace services provided by contracted entities such as case management.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-based agencies

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Self Direction Assistance

Provider Category:

Agency

Provider Type:

Community-based agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

24-Hour Stabilization Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

24-Hour Stabilization Services are designed to meet the needs of customers who require short-term, temporary services outside of their existing homes. The service is directed at customers who are experiencing acute behavioral conditions that result in difficulties in stabilization in the customer's existing habilitation setting.

Stabilization functions may include but are not limited to development of a sustainable behavior plan and interventions, implementation of positive and necessary behavior interventions, monitoring and tracking of individuals' behaviors, remediation of negative peer to peer interactions, resolution of other issues that are jeopardizing the customer's current service delivery, technical assistance to habilitation service providers serving the customer, and follow-up review on individual progress and phone consultation regarding remediation of identified issues.

24-Hour Stabilization Services providers must ensure that direct support staff working in the settings receives the basic direct support staff training that is required of all direct support staff in the waiver plus an additional 20 hours of training targeting the unique needs of customers who seek the 24-Hour Stabilization Service.

24-Hour Stabilization Service providers will be required to submit their curriculum and show documentation of staff completion of this additional 20 hours of training. In addition, providers must document the credentials and experience of the trainer or trainers proposed by the provider and this documentation must be approved in advance by the OA.

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

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

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

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

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

the existing behavior plan where appropriate and will address customer's respective needs.

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

24-Hour Stabilization Services require prior approval by the OA.

The OA will establish and maintain a minimum of four homes statewide for this service provision. Each home will have four single bedrooms.

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

The services are temporary and short-term in nature. A customer will typically receive no more than 90 consecutive days of 24-Hour Stabilization Services but may be approved for additional days by the OA. The initial goal of the OA is that these temporary services would last on average no more than 30 consecutive days per customer.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 24-Hour Stabilization Services

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

59 Ill. Adm. Code 115

Certificate *(specify):*

Other Standard *(specify):*

59 Ill. Adm. Code 50
59 Ill. Adm. Code 116
59 Ill. Adm. Code 120

The provider must have a current contract with the Operating Agency and meet all contractual requirements.

Providers will be selected through a Request For Applications process. No more than two providers will be selected.

The provider's homes must be accessible.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Operating Agency

Frequency of Verification:

The Operating Agency verifies provider qualifications upon enrollment and on an ongoing basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adaptive Equipment

HCBS Taxonomy:

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

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

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

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

Service Definition (Scope):

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

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

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

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

This service is subject to prior approval by the OA.

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

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

There is a $15,000 maximum per customer per five-year period for any combination of Adaptive Equipment, Assistive Technology, Home and Vehicle Modifications, Remote Support – Equipment (which includes consultation, training, installation, equipment costs (lease or purchase), and/or maintenance/repair service agreements), and any monthly monitoring costs for Remote Support.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Equipment Vendors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adaptive Equipment

Provider Category:
Agency
Provider Type:

Equipment Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled vendors approved by the Operating Agency and customer/family.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

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

Assistive technology service means a service that directly assists a customer in the selection, acquisition, or use of an assistive technology device. Assistive technology includes –
a) The evaluation of the assistive technology needs of a customer, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the customer in the customary environment of the customer;
b) Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the customer;
c) Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
d) Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the personal plan;
e) Training or technical assistance for the customer, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the customer; and
f) Training or technical assistance for professionals or other persons who provide services to, employ, or are otherwise substantially involved in the major life functions of the customer.

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

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

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

This service is subject to prior approval by the OA.

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

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

There is a $15,000 maximum per customer per five-year period for any combination of Adaptive Equipment, Assistive Technology, Home and Vehicle Modifications, Remote Support – Equipment (which includes consultation, training, installation, equipment costs (lease or purchase), and/or maintenance/repair service agreements), and any monthly monitoring costs for Remote Support.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Equipment Vendors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Equipment Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled vendor approved by the Operating Agency and customer/family.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Upon Enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavior Intervention and Treatment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

- Approach is tailored to address the specific behavioral needs of the customer;
- Targeted skills are broken down into small attainable tasks;
- Direct support staff and family training is a key component so skills can be generalized and communication promoted;
- Services must be directly related to the customer's therapeutic goals contained in the personal plan and coordinated with the customer's individual education plan (IEP); and
- Success is closely monitored with detailed data collection.

A behavior consultant assesses the customer, including analysis of the presenting behavior and its antecedents and consequences, and develops written behavior strategies based upon the customer's individual needs. The strategies are a component of the PCP and must be approved by the customer, family, responsible QIDP, ISC and the other members of the planning team. Trained team members implement the planned behavior services. The behavior consultant monitors progress on at least a monthly basis and more frequently if needed to address issues with the customer's outcomes. A progress report is prepared by the behavior consultant and sent to the support planning team every six months. This progress report is available to State staff upon request to evaluate the efficacy of the treatment.

The behavior consultant supervises implementation of the behavior strategies. This includes training of the direct support staff and family to ensure that they apply the interventions properly, understand the specific services and outcomes for the customer being served, and know the procedures for reporting customer progress.

Professionals working closely with the customer's direct support staff, family, teachers and other school personnel provide services in the customer's home and other natural environments (excluding school). Direct support staff and families of customers receiving intensive behavior treatment are vital members of the behavior team. They must be involved in the initial training session to initiate services and must remain involved with the team, so they are able to carry through and reinforce the behaviors being worked on by the team.

This service requires prior approval by the OA.

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

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

There is a State fiscal year maximum of 104 hours.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Behavior Consultant

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavior Intervention and Treatment

Provider Category:

Individual

Provider Type:

Behavior Consultant

Provider Qualifications

License *(specify):*

225 ILCS 15/1 et. Seq.
68 Ill. Adm. Code 1400

Certificate *(specify):*

Board Certified Behavior Analyst (bacb.com)

Other Standard *(specify):*

1. Licensed clinical psychologist

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

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

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

5. Early Intervention Specialist with a Developmental Therapy credential or equivalent experience and training.

6. Professional with a Bachelors Degree in a human service field and who has completed at least 1,500 hours of training or supervised experience in the application of behaviorally-based therapy models consistent with best practice and research on individuals with intellectual and developmental disabilities.

The Provider must be a Medicaid Enrolled Vendor.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Operating Agency verifies upon enrollment and annual verification of national certification or continuation of licensure.

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Behavioral Services (Psychotherapy and Counseling)

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Psychotherapists
Individual	Licensed Counselors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services (Psychotherapy and Counseling)

Provider Category:
Individual

Provider Type:

Licensed Psychotherapists

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency

Frequency of Verification:

Operating Agency verifies upon enrollment.

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Behavioral Services (Psychotherapy and Counseling)

Provider Category:

Individual

Provider Type:

Licensed Counselors

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Social Worker
Professional Counselor

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency

Frequency of Verification:

Operating Agency verifies upon enrollment.

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Emergency Home Response Services (EHRS)

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Emergency Home Response Services (EHRS)

Provider Category:
Agency
Provider Type:

Certified vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by the Illinois Department on Aging

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Department on Aging
Operating Agency

Frequency of Verification:

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Accessibility Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Those physical adaptations to the private residence of the customer, required by the customer's PCP, that are necessary to ensure the health, safety, and welfare of the customer or enable the customer to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the customer. Excluded are those adaptations or improvements to the home that are of general utility, such as carpeting, roof repair, central air conditioning, and are not of direct medical or remedial benefit to the customer.

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

This service will not be duplicative of other services in the waiver. For example, nursing services beyond those covered in the State Plan, are a component of residential services. For participants who choose participant-directed supports, this service is included in the participants monthly cost limit. See Appendix C-4.

This service is subject to prior approval by the OA.

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

There is a $15,000 maximum per customer per five-year period for any combination of Adaptive Equipment, Assistive Technology, Home and Vehicle Modifications, Remote Support – Equipment (which includes consultation, training, installation, equipment costs (lease or purchase), and/or maintenance/repair service agreements), and any monthly monitoring costs for Remote Support.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Contractor
Agency	Construction Companies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Accessibility Modifications

Provider Category:

Individual

Provider Type:

Independent Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled vendor approved by the Operating Agency and customer/family

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Accessibility Modifications

Provider Category:

Agency

Provider Type:

Construction Companies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled vendor approved by the Operating Agency and customer/family.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

- [ ] **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Carriers
Agency	Special Recreation Associations
Agency	Community-based agencies
Agency	Public and private carriers

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Individual Carriers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Drivers must have appropriate state licenses and proof of insurance

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Special Recreation Associations

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Drivers must have appropriate state licenses and proof of insurance

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Community-based agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Drivers must have appropriate state licenses and proof of insurance

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Public and private carriers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must meet existing requirements for public and private carriers

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

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

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

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

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

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

Personal Support is intended to be a one on one service.

Personal Support is being expanded to include supports provided to a customer while hospitalized to foster communication, provide intensive personal care, and/or promote behavioral stabilization for the purpose of smooth transitions or preserve functional abilities. These are services in the PCP that cannot be provided by facility staff and are not a substitute for services the hospital is obligated to provide through its conditions of participation or under Federal or State law, or under another applicable requirement. Services in the PCP that cannot be provided by hospital staff will be provided by the Personal Support Worker.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal Support Worker
Agency	Community-Based Agencies and Special Recreation Associations

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Support

Provider Category:
Individual
Provider Type:

Personal Support Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Aged 18 or older and is deemed by the guardian or family to be qualified and competent to meet the customer's needs and carry out responsibilities assigned via the person-centered plan.

All personal support workers must have had criminal background and Health Care Worker Registry checks completed prior to employment, and annually thereafter.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Service entities and Waiver Operating Agency

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Support

Provider Category:
Agency
Provider Type:

Community-Based Agencies and Special Recreation Associations

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Agency must be under contract with the OA. Per these contracts, employees must complete IDHS-approved direct support personnel training and pass competency-based training assessments be certified as direct support personnel.

All employees must have had criminal background and Health Care Worker Registry checks completed prior to employment, and annually thereafter.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

specified in statute.

Service Title:

Remote Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

Remote Support includes the use of video, audio, door and window monitoring devices, or other technology which enables a customer to be more independent and less reliant on staff being physically present when receiving CILA supports and services. The use of remote supports will be considered on an individual, case-by-case basis when a customer and guardian, if applicable, requests the service and the Independent Service Coordination agency and provider support team agree it is appropriate and meets the health and safety needs of the customer. Remote Support requires prior approval from the OA and may only be used with full consent of the customer, guardian, if applicable, and anyone else residing in the same living space. Remote Support is limited to CILA customers. The use of this service is not intended to replace a customer's ability or right to engage with the community.

The type of equipment and where it is placed will depend upon the needs and wishes of the customer(s) and their guardian(s) (if applicable), the layout and construction of the home, and the company selected by the customer(s) or guardian(s) to provide the equipment. The installation of video/audio equipment in the home will be done at the direction of the customer(s). If the home is shared with others, the equipment will be installed in such a manner that it does not invade others' privacy. The remote device is controlled by the customer and can be turned on or off as needed. Video equipment for remote support monitoring cannot be placed in invasive areas, such as bedrooms or bathrooms, in accordance with 42 CFR Section 441.301(c)(4)(iii) for 1915(c) and 42 CFR Section 441.710(a)(1)(iii) for 1915(i).

Purchased or leased equipment, an initial installation fee, ongoing monthly rental charges and upkeep and maintenance of the devices are covered under this service.

Any Remote Support devices authorized under this service shall not duplicate services otherwise available through the state plan.

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

Remote Support is not available for customers who receive home-based services.

There is a $15,000 maximum per customer per five-year period for any combination of Adaptive Equipment/Assistive Technology, Home Modifications, Vehicle Modifications, Remote Support – Equipment (which includes consultation, training, installation, equipment costs (lease or purchase), and/or maintenance/repair service agreements) and any monthly monitoring costs for Remote Support. See Appendix C-4.

This service is subject to prior approval by the OA.

All items shall meet applicable standards of manufacture, design and installation. All purchased items shall be the property of the customer or the customer's family.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Electronic Communication Equipment and Monitoring Company

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Support

Provider Category:

Agency

Provider Type:

Electronic Communication Equipment and Monitoring Company

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The monitoring agency must be capable of simultaneously responding to multiple signals for help from customer's remote support equipment. The monitoring agency's equipment must include a primary receiver, a stand-by information retrieval system and a separate telephone service or other data transmission such as wireless cellular service, a stand-by receiver, a stand-by backup power supply, and a telephone line or other data transmission such as wireless cellular service monitor. The primary receiver and back-up receiver must be independent and interchangeable. The clock printer must print out the time and date of the emergency signal, the remote support client's Medical identification code (PIC) and the emergency code that indicates whether the signal is active, passive, or a responder test. The telephone line or other data transmission such as wireless cellular service monitor must give visual and audible signals when an incoming telephone line or other data transmission such as wireless cellular service is disconnected for more than 10 seconds. The monitoring agency must maintain detailed technical and operations manuals that describe remote support elements including remote support equipment installation, functioning and testing; emergency response protocols; and record keeping and reporting procedures. Electronic communication equipment company and monitoring company don't need to be the same company.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Skilled Nursing

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Skilled Nursing

Provider Category:
Individual

Provider Type:

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

Provider Qualifications

License *(specify):*

225 ILCS 65/1 et seq.
68 Ill. Adm. Code 1300

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Operating Agency and Medicaid Agency

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Employment - Individual Employment Support

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Supported Employment – Individual Employment Support (SEI) services consist of ongoing supports that enable customers, for whom sustained competitive integrated employment is unlikely due to the nature of the customer's disabilities and absent the provision of supports, to maintain competitive employment in an integrated setting and at an employer identified by the customer through informed choice.

SEI services facilitate the maintenance and enhancement of employment which is aligned with a customer's interests, skills, desires and conditions of employment. It may also include self-employment.

SEI services do not include supporting paid employment or a facility-based setting.

The expected outcome of SEI is sustained competitive integrated employment that is well-matched to the customer's interests, strengths, priorities, and abilities, and that meets the customer's personal and career goals.

Eligibility and Authorization:
SEI services are available only to customers who are engaged in competitive integrated employment and who have been successfully closed and transitioning from supports provided by the Illinois Department of Human Services, Division of Rehabilitation Services, Vocational Rehabilitation program.

SEI services are authorized only for employment opportunities for which customers are compensated at or above (the higher of) local, state, or federal minimum wage and to the same degree as the customary wage and benefit levels of employees performing the same work who do not have disabilities.

SEI services may not supplant services typically available from the Division of Rehabilitation Services' Vocational Rehabilitation or are otherwise available under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act. Documentation must be maintained by the provider that the non-waiver employment services noted above (under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act) have been successfully exhausted.

SEI services must be reviewed no less than annually, coinciding with the development or revision of the PCP.

Employment Settings:
SEI services may only be conducted within (or associated to) integrated settings in which persons without disabilities are employed and where customers have contact with co-workers, consumers, supervisors and others without disabilities who are not paid supports.

Service Array:
SEI services provide intermittent or periodic job coaching, systematic instruction, job analysis, assistance with obtaining accommodations, benefits counselling or financial analysis, assistance with training or retraining, support in improving productivity, assistance with scheduling, support with efforts to obtain benefits, mobility training, assistance in fostering advancement opportunities, facilitation of communication between the customer and business co-workers, supervisors or consumers and other workplace assistance services which enable the customer to sustain competitive integrated employment or self-employment.

SEI service providers are responsible for the delivery of all personal assistance needs required by the customer during the time that SEI services are provided. Personal assistance needs should be intermittent, and while a component of SEI, shall not comprise the entirety of the services being provided and providers of SEI services must ensure that the on-going personal assistance needs, which extend beyond natural supports, can be met when the provider is not present.

SEI services are individualized and provided at a ratio of 1:1, staff member to customer.

Support Changes:
The option to change the amount of supports provided is based on a change in needs and/or on an assessment of needs for the customer. Should the customer and staff recognize a need for a change in supports, the change should be developed as part of the customer's person-centered plan and implementation strategy. Support changes that have been identified and are included in the implementation strategy must be reviewed regularly, but at least annually, by the Independent Service Coordination Agency to determine if the customer and staff continue to believe the existing supports are appropriate, if the supports are effective, and if further changes in supports should occur. It

is expected that, due to the nature of supports and services provided, customers will develop skills and natural supports (non-paid support relationships) which allow for greater independence.

Self-Employment:
SEI services may support the maintenance of Individual Self-Employment that is either based from a customer's residence or located within an integrated setting. Self-Employment must result in earned wages that, after deduction of business expenses and after a start-up period of no more than 1 year, are equal to or greater than (the higher of) local, state, or federal minimum wage. Self-Employment services provide identification of business opportunities, support to explore and identify sources of financing opportunities and limited on-going ancillary assistance. Waiver funds offered through SEI may not be used to defray the expense of starting up or operating Self-Employment.

Payments:
SEI service payments are only made for individual employment which meets competitive and integrated criteria. SEI service payments are not authorized for supervisory, training, support and adaptation activities typically offered by the employer to workers in similar positions or for group employment, non-paid prevocational activities (such as volunteering or internships paid below minimum wage) or time during which provider staff are not actively engaged in support.
SEI services include a rate component for transportation for the staff member to travel to the employment site but customer facing time spent transporting the customer to and from a worksite is not considered billable time. Billable time related to transportation training shall be authorized only if the customer's PCP indicates a specific need for transportation training and the transportation training is being provided. Transportation training must result in the eventual reduction of direct support related to travel.

Adaptations, supervision and training under SEI, provided to the customer or to supervisors or coworkers on behalf of the customer, may include non-customer facing portions of time which support continued successful employment. However, a direct service benefiting the customer's sustained employment outcome must be provided in order to bill for the time.

Duplication of Services:
SEI services may be combined with other services so long as the combined services are not duplicative, including the prohibition of:
-billing other non-residential waiver services at the same time as SEI.

-billing SEI services which are redundant or overlapped with Division of Rehabilitation Services' Vocational Rehabilitation program payments or services.
A customer's PCP may include more than one non-residential habilitation service (Supported Employment – Group Employment Services, Community Day Services, VDS); however, they may not be billed for during the same period of time (e.g., the same 15 minute or hour unit of time).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
-Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
-Payments that are passed through to users of supported employment services; or
-Payments for training that is not directly related to a customer's supported employment program.

Billing:
SEI services shall be billed in 15-minute increments.
Requirements:
SEI services must be:
-included in the Career and Income portion of the individual's PCP.
-approved by the ISC agency representative.
-validated by the Division of Developmental Disabilities based on criteria including:
- o setting
- o hourly wage or salary
- o number of work hours per week
- o benefits

o location
o duration of employment
o job title
o employer

New SEI service requests post 1/1/21 require successful closure from the Division of Rehabilitation Services' Vocational Rehabilitation program.

SEI service providers must:
• Comply with all Illinois Department of Human Services (IDHS), Division of Developmental Disabilities (DDD) requests for information on case notes, billing records, employment records, including pay details, and other items as requested, including progress towards employment and career goals.
• Allow DDD, Bureau of Quality Management to review the customer's file as part of their survey process.
• Recognize, and document in the customer's record, changes in health behavior, work productivity or overall condition.
• Report identified safety and sanitation hazards that occur at the worksite to employers having the responsibility to remedy the condition.

In circumstances where the provider of Supported Employment – Individual Employment Support wishes to hire the customer, in order to preserve the Medicaid free choice of provider requirement, the provider must ensure a policy exists related to the hiring and supervision of the customer which explicitly informs the customer of the option to identity and utilize services and supports from another provider and that the policy has been shared with the customer. In this circumstance, the provider must also ensure that the role(s) which have been identified meet(s) the threshold of competitive integrated employment.

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

The annual rate is spread over a State fiscal year maximum of 1,200 hours for any combination of day programs (listed above). Monthly payment is limited to a maximum of 115 hours for any combination of day programs. SEI is limited to 5 hours per day.

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

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

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

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment - Individual Employment Support

Provider Category:
Agency
Provider Type:

Community-Based Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Job Coach Requirements:

The Agency must be under contract with the OA. Per these contracts, employees must complete OA-approved direct support personnel training and pass competency-based training assessments and be certified as Direct Support Personnel.

All employees must have had criminal background and Health Care Worker Registry checks completed prior to employment.

Job Coaches must possess valid High School Diploma or GED.

If in the performance of duties employees are required to utilize either agency or personal vehicles, a valid driver's license and automobile liability insurance is required.

Employees providing Supported Employment Individual and Supported Employment Group supports and services receive training in the tenets and application of Competitive Integrated Employment activities as determined by the employing Agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Employment – Small Group Supports

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Supported Employment – Small Group Supports (SEG) services consist of ongoing supports that enable customers to engage in provider facilitated integrated group employment which supports the acquisition of skills and knowledge which lead to a successful transition into individualized competitive integrated employment or self-employment. SEG may supplement individualized competitive integrated employment or self-employment when it is only part-time but should not be utilized as a final destination with services into perpetuity. SEG services facilitate the enhancement of employment skills aligned with each customer's interests, skills, desires and conditions of employment.

Eligibility and Authorization:
The provision of SEG services presumes all customers are capable of working in individualized competitive integrated employment and/or self-employment.
SEG services do not require successful closure and transition from supports provided by the Illinois Department of Human Services, Division of Rehabilitation Services, Vocational Rehabilitation program.

SEG services authorization and re-authorization require the PCP to include, in the career and income section, opportunities are being provided to the customer through this service on an on-going basis, which support the customer's achievement of independence and transition to competitive integrated employment. The PCP shall also document and address any barriers to the above.

SEG services are authorized only for employment opportunities, in integrated settings, for which customers are compensated at or above (the higher of) local, state or federal minimum wage and to the same degree as the customary wage and benefit levels of customers performing the same work who do not have disabilities.

SEG services must occur at an employer identified by the customer through informed choice.

The SEG service provider is responsible for training, supervision and support of customers in experiences which allow opportunities for routine interactions with others without disabilities in the setting and involvement from supervisors and co-workers without disabilities (not paid to deliver this service) in supervision and support.

Customers receiving SEG services, who are not yet working in individualized competitive integrated employment or self-employment, shall be encouraged, on an ongoing basis, to explore and develop their interests, strengths, and abilities relating to individualized competitive integrated employment and/or self-employment.
Customers utilizing SEG services to supplement individualized competitive integrated employment or self-employment that is only part time, shall be offered assistance and be supported to utilize all available services and supports, including increasing hours in individualized competitive integrated employment, to transition fully to individualized competitive integrated employment as an alternative to continuing this service.

Employment Settings:
SEG services may only be conducted within (or associated to) integrated settings in which persons without disabilities are employed and where customers have contact with co-workers, consumers, supervisors and others without disabilities who are not paid supports. The setting must meet all HCBS setting standards and not isolate customers from others in the setting who do not have disabilities.

SEG service settings cannot be provider-owned, leased or operated settings. The settings must be integrated in and support full access of customers to the greater community, including opportunities to learn about and seek individualized integrated employment or self-employment, engage in community life, and control their earned income.

Service Array:
SEG service providers are responsible for the delivery of all personal assistance needs required by the customer during the time that SEG services are provided. Personal assistance needs, while a component of SEG, shall not comprise the entirety of the services being provided and providers of SEG services must ensure that the on-going personal assistance needs, which extend beyond natural supports, are considered in transition to individualized competitive integrated employment.
SEG services must be necessary and appropriate to meet the employment goal(s), as defined in the PCP, and provides job coaching, job analysis, training and systematic instruction, transportation training, development of natural supports, assistance with communication with employer or potential employer, and facilitation of employment related meetings involving the employer (performance evaluations, compliance training, department

meetings).

SEG services are provided at a ratio of 1:3 or 1:6, staff member to customer.

Support Changes:
The option to change the amount of supports provided is based on a change in needs and/or on an assessment of needs for the customer. Should the customer and staff recognize a need for a change in supports, the change should be developed as part of the customer's person-centered plan and implementation strategy. Support changes that have been identified and are included in the implementation strategy must be reviewed regularly, but at least annually, by the Independent Service Coordination Agency to determine if the customer and staff continue to believe the existing supports are appropriate, if the supports are effective, and if further changes in supports should occur. It is expected that, due to the nature of supports and services provided, customers will develop skills and natural supports (non-paid support relationships) which allow for greater independence.

Payments:
SEG service payments are only made for group employment which meets integrated criteria. No payments will be authorized for non-paid prevocational activities (such as volunteering), employment training provided in non-integrated, facility based settings, time during which provider staff are not actively engaged in support or for supervisory, training, support and adaptation activities typically offered by the employer to workers in similar positions.
SEG services includes 13.5 program related transportation miles per day, per customer, for supporting groups to transport customers to the work location.

SEG1: Small Group Level 1 (1:6 staff to customer ratio)
SEG2: Small Group Level 2 (1:3 staff to customer ratio)

Duplication of Services:

SEG services may be combined with other services so long as the combined services are not duplicative, including the prohibition of:
-billing other non-residential waiver services at the same time as SEG.
-billing SEG services which are redundant or overlapped with Division of Rehabilitation Services Vocational Rehabilitation program payments or services.

A customer's PCP may include more than one non-residential habilitation service (Supported Employment – Individual Employment Services, Community Day Services); however, they may not be billed for during the same period of time (the same 15 minute or hour unit of time).

Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
-Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
-Payments that are passed through to users of supported employment services; or
-Payments for training that is not directly related to a customer's supported employment program.

Billing:
SEG services shall be billed in 15-minute increments.
SEG1: Small Group Level 1 (1:6 staff to customer ratio)
SEG2: Small Group Level 2 (1:3 staff to customer ratio)

Requirements:
SEG services must be
-included in the Career and Income portion of the customer's PCP.
-approved by the ISC agency representative.

SEG service providers must:
-Comply with all Illinois Department of Human Services (IDHS), Division of Developmental Disabilities (DDD)

requests for information on case notes, billing records, employment records, including pay details, and other items as requested, including progress towards employment and career goals.
-Allow DDD Bureau of Quality Management to review the customer's file as part of their survey process.
-Remain in compliance with federal and state Departments of Labor (DOL).
-Recognize, and document in the customer's record, changes in health behavior, work productivity or overall condition.
-Report identified safety and sanitation hazards that occur at the worksite to employers having the responsibility to remedy the condition.

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

The annual rate is spread over a State fiscal year maximum of 1,200 hours for any combination of day programs. Monthly payment is limited to a maximum of 115 hours for any combination of day programs. SEG is limited to 5 hours per day.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment – Small Group Supports

Provider Category:

Agency

Provider Type:

Community-Based Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Job Coach Requirements:

The Agency must be under contract with the OA. Per these contracts, employees must complete OA-approved direct support personnel training and pass competency-based training assessments and be certified as Direct Support Personnel.

All employees must have had criminal background and Health Care Worker Registry checks completed prior to employment.

Job Coaches must possess valid High School Diploma or GED.

If in the performance of duties employees are required to utilize either agency or personal vehicles, a valid driver's license and automobile liability insurance is required.

Employees providing Supported Employment Individual and Supported Employment Group supports and services receive training in the tenets and application of Competitive Integrated Employment activities as determined by the employing Agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Temporary Assistance

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Service Definition *(Scope):*

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

Temporary Assistance services are provided on an emergency, temporary basis because of the absence or incapacity of the persons who normally provide unpaid care. Absence or incapacity of the primary caregiver(s) must be due to a temporary cause, such as hospitalization, illness, injury, or other emergency situation. Temporary Assistance services are not available for caregiver absences for vacations, educational or employment-related reasons, or other non-emergency reasons.

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

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

Temporary Assistance may function as an extension of behavioral and therapy services. Extension of services means activities by the Temporary Assistance/Personal Support worker who assists the customer to implement a behavioral, occupational therapy, physical therapy, or speech therapy plan to the extent permitted by state law and as prescribed in the PCP. Implementation activities include assistance with exercise routines, range of motion, reading the therapists directions, helping the customer remember and follow the steps of the PCP or hands-on assistance. It does not include the actual service the professional therapist provides.

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

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

The need for Temporary Assistance and the scope of the needed services must be documented in the PCP. The rate, amount and frequency for this service must be specified in the Service Agreement(s) and in the PCP.

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Special Recreation Associations
Individual	Temporary Assistance/Personal Support Worker
Agency	Community-Based Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Temporary Assistance

Provider Category:

Agency

Provider Type:

Special Recreation Associations

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

The Agency must be under contract with the OA. Per these contracts, employees must complete DHS-approved direct support personnel training and pass competency-based training assessments and be certified as direct support personnel.

All employees must have had criminal background and Health Care Worker Registry checks completed prior to employment.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operations Agency

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Temporary Assistance

Provider Category:

Individual

Provider Type:

Temporary Assistance/Personal Support Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Aged 18 or older and is deemed by the guardian or family to be qualified and competent to meet the customer's needs and carry out responsibilities assigned via the PCP.

All personal support workers must have had criminal background and Health Care Worker Registry checks completed prior to employment.

Verification of Provider Qualifications

Entity Responsible for Verification:

Financial Management Service entities and Waiver Operating Agency

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Temporary Assistance

Provider Category:

Agency

Provider Type:

Community-Based Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Agency must be under contract with the OA. Per these contracts, employees must complete IDHS-approved direct support personnel training and pass competency-based training assessments and be certified as direct support personnel.

All employees must have had criminal background and Health Care Worker Registry checks completed prior to employment.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Training and Counseling Services for Unpaid Caregivers

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training

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

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

Service Definition *(Scope):*

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

Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to customers. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a customer served in the Waiver. This service may not be provided in order to train paid caregivers or school workers.

Training includes instruction about treatment regimens and other services included in the PCP, use of equipment specified in the PCP, and includes updates as necessary to safely maintain the customer at home. Training furnished to individuals who provide uncompensated care and support to the customer must be directly related to their role in supporting the customer in areas specified in the PCP.

Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the customer. All training for individuals who provide unpaid support to the participant must be included in the customer's PCP. Counseling similarly must be aimed at assisting unpaid individuals who support the customer to understand and address customer needs.

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

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

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training and Counseling Services for Unpaid Caregivers

Provider Category:
Agency
Provider Type:

Specialized Training providers

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Training programs or events deemed qualified by the customer/family and approved by the OA. Examples include CPR instruction, first aid, and programs on disability-specific topics such as behavior intervention techniques, epilepsy, autism, etc.

Verification of Provider Qualifications
Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training and Counseling Services for Unpaid Caregivers

Provider Category:
Individual
Provider Type:

Licensed counselors

Provider Qualifications
License *(specify):*

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

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modification

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**

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

Service Definition *(Scope):*

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

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

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

The following are specifically excluded:
1. Adaptations or improvements to the vehicle that are of general utility and are not of direct medical or remedial benefit to the customer;
2. Purchase or lease of a vehicle; and
3. Scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications. The family with whom the customer lives must own the vehicle that is adapted.

This service is subject to prior approval by the OA.

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

There is a $15,000 maximum per customer per five-year period for any combination of Adaptive Equipment/Assistive Technology, Home Modifications, Vehicle Modifications, Remote Support – Equipment (which includes consultation, training, installation, equipment costs (lease or purchase), and/or maintenance/repair service agreements) and any monthly monitoring costs for Remote Support. See Appendix C-4.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Equipment Vendor and Installer

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modification

Provider Category:

Agency

Provider Type:

Equipment Vendor and Installer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Medicaid Enrolled vendor approved by the Operating Agency and the customer/family.

Verification of Provider Qualifications

Entity Responsible for Verification:

Waiver Operating Agency

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

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

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

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

Check each that applies:

☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

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

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

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

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

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

Appendix C: Participant Services

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

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

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

◉ **Yes. Criminal history and/or background investigations are required.**

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

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

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

The Financial Management Service (FMS) entity/entities are required to obtain criminal background checks and not enroll or retain independent personal support workers (domestic employees) if the person has been convicted as described above. The FMS vendor obtains the criminal background check on behalf of all customers who hire independent personal support workers. The results are kept on file with the FMS vendor.

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

The Medicaid Enrollment Agreement signed by the providers, as well as the contractual agreement signed by the FMS entities, includes the requirement for background investigations. The OA annually reviews compliance with this provision through the statistically valid sample of Waiver customers by obtaining evidence of the completed investigations by their providers. In addition, the OA obtains and reviews on-going reports from the FMS entities of the dates of the completed investigations for the workers they enroll. The results of these reviews are shared with the MA on a summary basis.

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

Annually, the MA conducts comprehensive focused onsite reviews using a statewide sample of customer records. PCP implementation and satisfaction are monitored during these reviews. The MA submits findings from routine monitoring to the OA for follow-up and correction.

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

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

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

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

The Medicaid Agency (MA) initiated a provider enrollment system in Fiscal Year 2016 in response to requirements of the Affordable Care Act. The Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system is a web-based system designed to improve provider access, and to ensure customers receive timely and high-quality Medicaid services, including services provided to Medicaid waiver customers. Providers must be enrolled in the IMPACT system prior to being reimbursed for services. Background checks are completed on each provider during

the enrollment process. Information about all convictions is shared with the MA's Office of Inspector General (OIG) for review and follow-up. Certain felony convictions will prevent providers from being enrolled in the IMPACT system. The decision to reject an enrollment application on the basis of a felony conviction is determined by the OIG. Providers must meet all qualifications and pass all screening checks to be approved and entered in IMPACT. A provider cannot be enrolled and serve Medicaid customers unless all mandatory screenings have been conducted. Providers must meet all qualifications and pass all screening checks to be approved and entered in IMPACT (HFS Inspector General's Office, the Illinois Department of Public Health's Health Care Worker Registry, a Healthcare Worker Background Check, the Illinois Department of Professional and Financial Regulation registry, etc.).

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

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

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

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

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

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

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

Abuse/neglect screenings are required for all domestic employees hired on or after July 1, 2007, who provide Personal Support or Temporary Assistance services. Such individuals may not be employed in any capacity until the employer has checked the individual against the Ill. Department of Public Health, Health Care Worker Registry and the Ill. Department of Children and Family Services Registry. The FMS entities conduct the registry checks for all personal support workers employed directly by the customer or their representative.

Abuse/Neglect screenings are required for all individuals providing Residential Habilitation, Community Day Services, Supported Employment, Self-Direction Assistance, Personal Support, or Independent Service Coordination (ISC) entities. Such individuals may not be employed in any capacity until the employer has checked the individual against:

-The Illinois Department of Public Health (IDPH) Health Care Worker Registry, and the Illinois Department of Children and Family Services (DCFS) State Central Register (Children's Abuse and Neglect Tracking System - CANTS). If either database reports substantiated or indicated findings of physical or sexual abuse or egregious neglect, the person may not be employed. For providers who don’t provide services to children (under the age of 18), the employee is authorized to begin providing services pending the outcome of the CANTS check.

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

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

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

The OA and the MA, through a representative sample, review providers and FMS entities for compliance with this requirement.

Appendix C: Participant Services

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

Note: Required information from this page (Appendix C-2-c) is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally

responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

☐ **Self-directed**

☐ **Agency-operated**

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

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

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

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

Parents, other relatives, and legal guardians may provide Personal Support, Temporary Assistance, and Non-Medical Transportation services. The relative or legal guardian must meet the same provider qualification criteria, and pass the required background checks, that are applicable to any provider rendering the same services.

Parents, other relatives, and legal guardians may not provide host family services (i.e., foster care and other shared living arrangements) under Residential Habilitation services. This prohibition is specified in Illinois Administrative Code, available upon request from either the Medicaid Agency (MA) or Operating Agency (OA).

Legally responsible relatives (i.e., spouses) may not be paid to provide waiver services, as specified in Appendix C-2(d) above.

The PCP governs the services to be provided, including those provided by relatives and legal guardians. For customers who exercise employer authority, the Financial Management Service (FMS) entity receives time sheets detailing the date and time of services delivered. The FMS entity conducts routine quality assurance activities.

The ISC, plays a key role in monitoring the implementation of the PCP and reporting any non-compliant issues or problems to the OA if direct interventions by the ISC do not work.

The OA through its representative sample, reviews Personal Support, Temporary Assistance and Non-Medical Transportation, regardless of the provider relationship.

Payment arrangements to relatives and legal representatives may be reviewed and denied by the OA. Decisions to deny by the OA are subject to waiver appeal rights.

○ **Other policy.**

Specify:

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

Customers in the Adult Waiver and their families, guardian if applicable and ISC staff are responsible for selecting needed services and service providers, as the Adult Waiver is largely directed by customers and their families.

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

The OA reviews and approves service providers for participation in the Adult Waiver based only on the provider qualifications specified in the Waiver.

The MA enrolls all willing and qualified providers that are chosen by customers in the Adult Waiver and their families.

Information regarding provider qualifications and program guidelines is continuously available on the OA's website at http://www.dhs.state.il.us/page.aspx?item=47336. This website lists all types of providers within the developmental disabilities service system, briefly describes what each does, lists requirements and qualifications, links those interested to regulatory documents and forms, and provides contact information.

Potential providers must review the regulatory documents linked to the website. They must also complete the required forms for their provider type and submit them to the contact person listed.
Each provider must complete a Medicaid Provider Enrollment agreement, which is a three-way agreement among the provider, OA, and MA.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
C1 Number and percent of newly enrolled licensed/certified waiver service providers who meet provider requirements in the approved waiver prior to providing waiver services. N: Number of newly enrolled licensed/certified waiver service providers who meet provider requirements in the approved waiver prior to providing waiver services. D: Total number of newly enrolled licensed/certified providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HFS IMPACT System

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
C2 # and % of enrolled lic/cert waiver service providers who continue to meet provider requirements in the approved waiver prior to continuing to provide waiver services. N: # of enrolled lic/cert waiver service providers who continue to meet provider requirements in the approved waiver prior to continuing to provide waiver service. D: Total # of enrolled lic/cert providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
HFS IMPACT System

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

Data Aggregation and Analysis:

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

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

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

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
HFS IMPACT System

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

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
HFS IMPACT System

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

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
C5 Number and percent of new ISC staff who receive training in accordance with state requirements and the approved waiver prior to providing waiver services. N: Number of new ISC staff who receive training in accordance with state requirements and the approved waiver prior to providing waiver services. D: Total number of new ISC staff.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ISC Staff Training Reports

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
C6 Number and percent of ISC staff who receive training in accordance with state requirements and the approved waiver prior to continuing to provide waiver services. N: Number of ISC staff who receive training in accordance with state requirements and the approved waiver prior to continuing to provide waiver services. D: Total number of ISC staff.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ISC Staff Training Reports

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

Data Aggregation and Analysis:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA DSP Training Report

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

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

Data Aggregation and Analysis:

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

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

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

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

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

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

For training, the MA will request reports from the OA to verify that ISC staff initially meet, and continue to meet, provider training requirements. These reports will also be shared during the quarterly meetings.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

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

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

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

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

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

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

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

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

Outstanding trainings will be completed within 60 days.

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

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

- ( ) **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- (●) **Applicable** - The state imposes additional limits on the amount of waiver services.

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

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

In addition to the information contained in the OA's Waiver Manual, each participant receives an initial award letter that contains service limits.

The service limits are discussed verbally during the annual person centered planning process. The ISC reviews service limits with the participant and guardian, if applicable. The written person centered plan is signed by the participant, or his or her guardian (if one has been appointed), and the ISC. Providers responsible for the plan's implementation must also sign the plan.

Maximum for Modifications and Tangible Items
There is a $15,000 maximum per individual per five-year period for any combination of Adaptive Equipment/Assistive Technology, Home and Vehicle Modifications, Remote Support – Equipment (which includes consultation, training, installation, equipment costs (lease or purchase), and/or maintenance/repair service agreements), and any monthly monitoring costs for Remote Support. Within the same five-years, there is also a $5,000 maximum per address for permanent home modifications for rented homes. Individuals are informed of their right to request a fair hearing in the event any requests are denied. Individuals are notified of the limits in the OA's Waiver manual.

Any combination of Community Day Services and Supported Employment services cannot exceed 1200 hours per year. This limit was established through a review of historical expenditures and is based on hours of operation for day programs established in Illinois Administrative Code, Title 59, Chapter 1, Part 119. Additionally, Supported Employment – Individual Employment Support counts toward the 1,200 hour annual limit for all day programs combined. IL0350.R04.10--The customer will not experience a reduction in service based on the revised service limits and the OA will transition all customers currently using the service in accordance with the transition plan.

Behavior Intervention and Treatment services cannot exceed 104 hours per year. These limits were established through a review of historical expenditures.

Any combination of Individual Counseling, Group Counseling, Individual Therapy, and Group Therapy cannot exceed a maximum of 60 hours per fiscal year. These limits were established through a review of historical expenditures.

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

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

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

The annual home-based supports budget limits are based on the Illinois Home-Based Support Services Law for Mentally Disabled Adults [405 ILCS 80/2-6 (a) and (b)]. The limits are based on Social Security benefit levels and are adjusted each January when Social Security benefits are adjusted for cost of living increases. These statutory budget limits were set through a public legislative process that included opportunities for public comment by advocates and customers with mental disabilities and their families.

The total amount of Waiver services provided in any month is determined by the PCP of the customer within the program maximums. The annual PCP is developed by the ISC and is based on assessments of the customer's needs.

Written notices of changes to limits are sent to all customers/guardians (as applicable), Financial Management Service (FMS) entities, and Independent Service Coordination (ISC) agencies by the OA.

The monthly home-based support services budget limits are currently set in statute [405 ILCS 80/2-6 (a) and (b)] as: "(a) three hundred percent of the monthly federal Supplemental Security Income payment for an individual residing alone if the adult with a mental disability is not enrolled in a special education program by a local education agency, or (b) two hundred percent of the monthly Supplemental Security Income payment for an individual residing alone if the adult with a mental disability is enrolled in a special education program by a local education agency", together with natural supports, general community resources, school-based services (for young adult customers still attending school), and Medicaid State Plan services are sufficient to meet the customer's needs. If the health and welfare of the customer cannot be assured on a long-term basis within the cost limit of home-based supports in combination with other natural supports and community resources, the customer will be considered for other service options within the Waiver, including residential service supports that are not customer-directed and some that are provided 24 hours a day, seven days a week. Customers are notified of the opportunity to request a fairing hearing if enrollment is denied.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

As reflected in the Statewide Transition plan, the OA is in the process of validating all Residential Habilitation (residential) and Community Day Services (non-residential) providers in the waiver through onsite and desk validation processes prior to March 17, 2023. The onsite validation tool includes interviews with customers receiving services and front-line staff and site observations. In addition, all sites are responsible for submitting provider policies that address settings concerns and evidence of compliance with the settings rule. After March 2023, ongoing monitoring will include the incorporation of HCBS settings questions into reviews and surveys done by the Bureau of Quality Management (BQM) and the Bureau of Accreditation, Licensure and Certification (BALC). The person-centered planning process that directs customer's services is being strengthened to include specific questions on HCBS settings compliance based on the customer's perspectives and ongoing experiences receiving services in the community. The Operating Agency (OA) is reviewing and updating Illinois rules, policies, procedures, forms and manuals to also reflect the highest level of commitment to the HCBS settings rule in the Statewide Transition Plan.

Ongoing oversight includes:
1) Annually, the OA conducts nursing visits with all residential providers. Nurses make additional onsite visits as needed.
2) Every two years, BALC surveys every site under the waiver, focusing on compliance with the OA rules. Their comprehensive survey tool will include HCBS settings related questions.
3) Annually, BQM pulls a random sampling of people receiving services to review their PCP, services and experiences. Site visits are unannounced and comprehensive in nature. Results are discussed with the provider prior to exit and, depending on the nature of the findings, a plan of correction is required by the OA. Results from the collective site visits are reported on a quarterly basis to the Waiver Quality Management Committee which includes key staff from the MA. Their tools are being updated to include HCBS settings questions. BQM reviews all providers at a minimum of every three years.
4) The OA also contracts with ISC agencies who visit each customer a minimum of four visits a year to develop a PCP, ensure the plan is being implemented and assure the ongoing health, welfare and safety of the waiver customers.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person Centered Plan (PCP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- ☐ **Social Worker**
  Specify qualifications:
- ☒ **Other**
  Specify the individuals and their qualifications:

The ISC agency staff who provide Individual Service and Support Advocate (ISSA) services are Qualified Intellectual Disabilities Professionals. Per contractual agreement with the OA, the ISCs are prohibited from providing direct service to waiver customers.

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

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

Upon enrollment, and annually thereafter, each customer/legal representative is given a statement of rights by the ISC. The statement of rights can be found at: http://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL462-1201.pdf. The rights statement is consistent with the final Medicaid Home and Community Based Services rules CMS 2249F and 2296F. The Rights statement includes information on customer's retention of rights, exercising their rights (and restriction of rights if a guardian has been appointed), non-discrimination, selection of providers, humane care and person centered plans, abuse, neglect and exploitation, coercion, restraints, seclusion, confidentiality, communication rights (mail/phone calls/visits), property rights, money and banking rights, labor rights, right to refuse services, medical and dental services, right to participate in their person-centered planning process, voluntary discharge/termination of services, right to file a grievance, right to view their clinical record, and how to report any infringements of their rights, report an Abuse, Neglect or Exploitation allegation or file a complaint/grievance.

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

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

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

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

The ISC provides information and support to enable the customer/legal representative to participate in and direct the planning process. The customer/legal representative is informed of the types of services provided under the Waiver, as well as options of all willing and qualified providers. The options discussed and the choices made by the customer/legal

representative are documented as part of the planning process.

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

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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

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

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

The ISC staff conducts a face-to-face comprehensive ICAP assessment of the customer. The ICAP gathers information on maladaptive behavior index, adaptive behavior index and service score and level. The psychological assessment gathers information on cognitive/intellectual functioning, developmental history, educational background, adaptive skill level, multi-axial diagnosis that includes a primary diagnosis, and recommendations for future service delivery. The physical assessment gathers information on the individual's physical condition. The assessment allows the customer to express his/her goals, which include those related to service needs, overall life goals or desires and their expectations for care. Goals are holistic and are not restricted to only needs that will be addressed by waiver services.

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

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

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

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

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

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

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

In (a) above, the Discovery Process is designed to gather information about a customer's preferences, interests, abilities, preferred environments, activities, identified outcomes, risk factors and supports needed in the areas of Home, Important Relationships, Career and Income, Health and Well Being, Communication, Life in the Community,

Recreation/Interests/Hobbies, Choice and Decision Making, and Future Plans. The ISC can obtain the information in various ways: conversations (face to face, phone, e-mails), record reviews, assessments/evaluations, provider agency notes and summaries. If the individual is currently enrolled in a DD Waiver service, the ISC agency must obtain information from the current provider agency(s).

c) Informing customer of services available under the waiver:

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

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

The use of the discovery process ensures information regarding the customer's outcomes, needs, and preferences are collected and compiled. The ICAP gathers information on maladaptive behavior index, adaptive behavior index and service score and level. The psychological assessment gathers information on cognitive/intellectual functioning, developmental history, educational background, adaptive skill level, multi-axial diagnosis that includes a primary diagnosis, and recommendations for future service delivery. The assessment collects and compiles information about the customer's strengths, needs, preferences, desired outcomes, health, and risk factors. The discovery process guides an interview with the customer. Topics covered include the customer's self-description, communication needs, relationships, living arrangements, work, abilities, health/medication issues, recreation, and community connections. The assessment discovery process is available upon request from the OA. The PCP must then be based on and address the assessed needs, preferences, and desired outcomes. Alternative services may be considered as responsive if the customer and family cannot specifically have what the customer and family prefer due to limitations identified.

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

The ISC is responsible for implementing the PCP and monitoring its on-going implementation and effectiveness. The ISC is charged with coordinating the various services chosen by the customer, including State Plan services for healthcare and medical needs, as well as generic supports. The ISC is responsible for ensuring that no duplication of services exists. The ISC is responsible for ensuring that providers are identified and linked for any services identified the customer may require beyond those authorized in the Waiver, i.e. medical services, non-emergency transportation to medical appointments, dental services, optometric services, etc. The ISC must then monitor that the services are delivered as specified in the PCP. The PCP includes all other services the customer is receiving, regardless of funding source. The PCP is then sent to each waiver provider listed on the PCP so the providers are aware of additional services or assistance in the residential setting. Providers are trained to report any changes in the customer situation to the ISC agency.

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

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

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

The PCP is completed prior to initial service implementation and updated at least annually thereafter. The PCP may be

updated more frequently should the customer's needs and circumstances change. The time and location of the assessment and PCP meetings are convenient to the customer and authorized representative.

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

PCPs are reviewed and adjusted during each assessment. Customers may request a change to the PCP at any time. During assessments, ISC staff educates the customer to call the ISC agency to request a new assessment or to report any changes in their living or medical situation that may affect their services.
PCPs can be edited or revised more frequently to meet the customer's changing needs or desires. Whenever there is a significant change in level of service needs or functioning (for example, hospitalization significantly impacting the customer's level of functioning), an assessment edit or revision is to be completed and additional services provided as needed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

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

The risk domains that must be assessed are: health/medical, safety (home), safety (community), safety (workplace), finances, behavioral and supports.

Strategies to mitigate risk must be incorporated into the PCP, including the consequences of choices that may involve risk, documenting the issues concerned and the decisions made. The team will describe, when it is necessary to do so, to the customer and the customer’s support network, how the preferences might be limited because of imminent significant danger to the customer’s health, safety, or welfare based on the following:
- The customer’s or guardian’s, if one has been appointed, history of decision-making and ability to learn from the natural negative consequences of decision-making;
- The possible long and short-term consequences that might result to the customer if the customer makes a poor decision;
- The possible long and short-term effects that might result to the customer if the provider limits or prohibits the customer or guardian from making a choice; and
- The safeguards available to protect the customer’s safety and rights in each context of choices.
ISC's address risk as part of the Discovery Process and PCP. Assessments must include the domains listed above and the minimum components described in the Discovery Process. Assessments must be performed at least annually or more frequently if indicated by the needs of the customer. When conducting risk assessments and making recommendations to mitigate risks, assessors should:
- Gather information from a variety of sources including the individual customer, guardian, family members, provider’s commercially or locally developed risk assessment, paid staff, record review, observation, and assessor direct knowledge of the customer.
- Recognize that some domains may not be applicable for all customers. In such cases, the assessor should include a brief explanation of why the domain is not applicable and, therefore, no risks are evident.
- Provide narrative information (including brief overview of current skills as well as potential and known risks) sufficient to guide the provider agency(ies).

Consideration should be given to both the risks associated with current activities of the customer as well as potential risks which inhibit the customer from pursuing his/her goals and fully participating in integrated settings.

Backup plans are developed as part of the PCP development process.

If the customer is receiving services from an agency, the agency is required to provide back-up personnel as needed. When the customer is exercising employer authority, the back-up plan is specific to the customer’s needs and may include family, other social service agencies, etc.

This waiver provides support services to Adults age 18 and older who live at home with other family members or in residential settings. As part of the person-centered planning process, the customer or guardian, if one has been appointed, can make arrangements with multiple providers who can be contacted as needed.

A back-up plan is necessary when the absence of the service presents a risk to the health, welfare and/or safety of the customer. The planning team evaluates the need and type of back-up plan taking into consideration natural supports and available waiver services. Customers residing with family members can enter into agreements with providers that can provide services in an emergency situation or provide staff substitutes when regular staff cannot work assigned hours.

The back-up plan is specific to the customer’s needs and preferences. ISC staff are trained to understand that a sufficient back-up plan is not just to rely on calling 911, but rather one that utilizes other formal social services agencies, as well as family, neighbors and friends, and assistive technology devices. Together, the ISC, customer and anyone else the

customer elects to be engaged in the process discuss the availability of both formal and informal options in the event that the authorized services in the PCP are not provided and establish a back-up plan to meet the customer's needs. The ISC assists the customer with posting the back-up plan in a location that is accessible and visible to the customer and other providers that support the customer. The back-up plans include the names and phone numbers of persons and agencies who are available to immediately assist the customer if needed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Operating Agency (OA) has day-to-day responsibility for completion and approval of PCPs. The MA, through its Quality Improvement System, reviews PCPs through the process described below. Annually, OA staff review the adequacy of PCPs through a representative sample during on-site quality assurance reviews. The representative sample size is determined using the Raosoft sample size calculator. The sampling methodology is based on a statistically valid approach that uses a 95% confidence level and a 5% margin of error. The OA completes a review of the representative sample at each ISC annually. Additional reviews are conducted in response to complaints or referrals from other state agencies (OIG, APS). This ongoing administrative activity allows the OA to ensure the ISCs are adhering to the rules, regulations, policies, and procedures. Prior to the review, the OA checks the CIRAS (Critical Incident Reporting and Analysis System) database to review any complaints/concerns for customers served in the ISC's area. Data from the OA reviews of ISC agencies are aggregated by the OA and shared with the MA staff as part of the Waiver Quality Management Committee (QMC) quarterly meetings.

The MA reviews a sample of PCPs when monitoring the OA. During these reviews, the PCPs are reviewed for compliance with state and federal regulations. Reports of findings are shared with the OA and recommendations for improvement are made. The OA responds to the MA reports both on an individual and systemic basis. The OA provides follow up on all MA reviews of ISC and provider agencies to ensure corrective actions and remediations have occurred within established timeframes. Discussions on Quality Management review findings and trends are discussed during quarterly meetings between the MA and OA. The MA reviews consist of record reviews, interviews with customers and staff, and direct observations.

The QIO determines a review schedule, based on the sample, and performs onsite record reviews to assess compliance with the performance measures (PM) as well as with all applicable state and federal requirements. Reports of findings are shared with the OA by individual PM, along with recommendations for remediation of findings and/or needed systemic improvement(s). Timeliness of remediation is reported back to the MA based on the requirements of each PM, either immediate, 30, 60, 90 days and any remaining outstanding remediation. Information related to onsite record reviews is also shared during quarterly meetings between MA and OA.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

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

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

Specify:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

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

The ISC is responsible for monitoring the implementation of the PCP and the customer's health, safety and welfare. ISC staff and customers develop the PCP together during the initial assessment and at each reassessment the PCP is reviewed and adjusted as needed. Waiver customers are provided with the opportunity to lead the PCP process. The OA administrative rules require that customers receive a new assessment at least annually, when there is significant change, or when the customer requests a new PCP.

The assessment addresses all aspects of customer function and supports. The ISC staff identifies services needed and makes the appropriate referrals, as agreed upon by the customer and the ISC staff during the PCP process. Referrals are made for a variety of services including those outside the services offered in the waiver. The ISC is charged with coordinating the various services chosen by the customer, including State Plan services for healthcare and medical needs, as well as generic supports. The ISC is responsible for ensuring providers are identified and linked for any services identified that the customer may require beyond those authorized in the waiver, i.e. medical services, non-emergency transportation to medical appointments, dental services, optometric services, etc. The ISC must then monitor that the services are delivered as specified in the PCP.

The minimum frequency of contact for monitoring the PCP's implementation, including direct, in-person contact with the customer, is quarterly. The quarterly monitoring visits are conducted in conjunction with the direct contact for PCP development. During the monitoring visit, the ISC reviews that the services delivered are in accordance with the PCP and that all services authorized in the PCP are being delivered.

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

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

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

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

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

For overall program monitoring related to PCP development and implementation, the OA monitors the ISC activity through a representative sample of customers on a continuous, on-going basis. Data is collected and analyzed as specified under the Quality Improvement sections in Appendices D and G on an on-going, continuous basis. Program monitoring includes the development and implementation of the PCP and ensuring that appropriate follow-up was completed as required. Summary reports are shared with the MA and discussed during quarterly Quality Management Committee

meetings. When problems are identified, they are documented, and remediation efforts are initiated by the OA. Remediation efforts may include revising PCPs, increased monitoring, technical assistance, plans of correction, voidance of claims, etc.

c) The frequency with which the monitoring is performed:

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

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

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

ISC staff also reviews the backup plan to ensure it is still in effect and if the backup plan was utilized, it is discussed with the customer to ensure its effectiveness. The PCP, service providers, backup plan or referrals to non-waiver services may be made or modified to ensure the customer's needs are adequately met based on these discussions.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
D1 Number and percent of customers' Person Centered Plans (PCPs) that address all personal goals identified by the assessment. N: Number of customers' PCP that address all personal goals identified by the assessment. D: Total number of customers' PCP reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D2 Number and percent customers' Person Centered Plans (PCPs) that address all needs identified by the assessment. N: Number of customers' PCPs that address all needs identified by the assessment. D: Total number of customers' PCPs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
D3 Number and percent of customers' Person Centered Plans (PCPs) that address all health and safety risk factors identified by the assessment. N: Number of customers' PCPs that address all customer health and safety risk factors identified by the assessment. D: Total number of customers' PCPs reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
D4 Number and percent of customers who receive Personal Support Services whose Person Centered Plan (PCP) includes a backup plan. N: Number of customers who receive Personal Support Services whose PCP includes a backup plan. D: Total number of customers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
D5 Number and percent of customers who were contacted quarterly by ISC staff in an effort to monitor service provision and to address potential gaps in service delivery. N: Number of customers reviewed who were contacted quarterly by ISC staff in an effort to monitor service provision and to address potential gaps in service delivery. D: Total number of customers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin or error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D8 Number and percent of customers that received updates to the Person Centered Plan (PCP) when there was a change in customer need. N: Number of customers that received updates to the PCP when there was a change in customer need. D: Total number of customers reviewed where a change in need was identified that were reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D9 Number and percent of customers who received services in the type, scope, amount, duration, and frequency as specified in the Person Centered Plan (PCP). N: Number of customers who received services in the type, scope, amount, duration, and frequency as specified in the PCP. D: Total number of customers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D10 Number and percent of customer records that indicate choice between waiver services and institutional care; and between/among services and providers. N: Number of customer records reviewed that indicate choice between waiver services and institutional care; and between/among services and providers. D: Total number of customers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

D1: If PCPs do not address required items, the OA will require the PCPs be corrected and the OA will provide training of the ISC staff. Remediation must be completed within 60 days.

D2: If PCPs do not address required items, the OA will require the PCPs be corrected and OA will provide training of the ISC staff. Remediation must be completed within 60 days.

D3: If PCPs do not address required items, the OA will require the PCPs be corrected and OA will provide training of the ISC staff. Remediation must be completed within 60 days.

D4: The ISC staff will develop and implement a PSW back up plan and make revisions to customers' PCP. Remediation within 30 days.

D5: OA will require customer be contacted and provide training to ISC staff. Remediation within 60 days.

D7: If PCP is untimely, the OA will require completion of overdue plan and justification from the ISC staff and provide training of ISC staff. Remediation within 60 days.

D8: If plans do not address required items, the OA will require that the plans be corrected and provide training of ISC staff. Remediation must be completed within 60 days.

D9: If a customer does not receive services as specified in the PCP, the OA will determine if a correction or adjustment of the PCP, services authorized, or services vouchered is needed. If not, services will be implemented as authorized. The OA may also provide training to the ISC staff. If the issue appears to be fraudulent, it will be reported by the OA/MA. Remediation must be completed within 60 days.

D10: The OA will assure that choice was provided as shown by the correction of documentation to indicate customer choice. The OA may also provide training to ISC staff. Remediation must be completed within 60 days.

The OA is responsible to ensure findings are remediated. The OA provides quarterly reports of these activities to the MA. Staff of the two State agencies review the reports on a quarterly basis.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

(a) The nature of the opportunities afforded to participants:

The waiver affords customers the opportunity to direct their services through employer authority and budget authority. The customer exercises choice and control over the workers who provide services. Customers also exercise decision-making authority and management responsibility for their budgets. Within the overall cost limit, the customers determine the type and amount of services to be purchased and establish rates for Personal Support Workers (PSWs).
In 2017, the OA introduced a new service under the waiver called Self-Direction Assistance. A Self-Direction Assistant (SDA) assists the customer (or the customer's family/representative, as appropriate) in arranging for, directing and managing services. Practical skills training is offered to enable families and customers to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal support workers, managing workers, and providing information on effective communication and problem-solving. The service/function includes providing information to ensure customers understand the responsibilities involved with directing their services. The extent of the assistance furnished to the customer or family is to be specified in the PCP. Customers are required to use a Fiscal Agent when hiring personal support workers who are not employees of a provider agency.

(b) How participants may take advantage of these opportunities:

Customers access customer directed services in the same manner they access all waiver services. The process starts with an assessment of eligibility by the ISC. Once a customer is enrolled in the waiver, the ISC agency will assist the customer in meeting their needs through the person-centered planning process. The ISC explains the options the customer has to direct their own services and budget. The ISC also explains the resources available to the customer to assist them in directing their services such as the Self Direction Assistance waiver service.

The OA provides a Consumer Handbook for Home Based Services which provides information on customer directed services and assists customers and their families in managing their services. This Handbook is available on the OA's website located at https://www.dhs.state.il.us/page.aspx?item=101181#a_toc16 .

(c) The entities that support individuals who direct their services and the supports that they provide:

Customers are supported to direct their own services by the following entities:
-Independent Service Coordination (ISC) Agencies conduct case management services as an administrative activity under the waiver, including PCP development and monitoring;
-A fiscal employer agency that provides Financial Management Services (FMS) as an administrative activity under the waiver, including making payments on behalf of the employer, completing required tax and other withholding and documentation; and
-An Self-Direction Assistance provider, if selected through an optional direct service under the waiver referred to as Self Direction Assistance (SDA), who assists the customer (or the customer's family or representative, as appropriate) in arranging for, directing and managing services.

(d) Other relevant information about the waiver's approach to participant direction:

The customer receives information about customer-directed services and supports during the PCP process. Information is presented in both written and verbal formats to ensure the customer and family understand the customer-directed option and can make an informed choice. Information is provided about decision-making budget authority up to the approved level of support. Specific information is provided about the roles and responsibilities of the parent or legal representative and the financial management services.

The customer always has the option of receiving agency-based services if they desire. The PCP can be amended at any time to change the provider of service to an agency-based model.

The customer's choice of the type of supports is documented as part of the PCP. Service Agreements are completed for each provider selected to work with the waiver customer.

If at any time the customer voluntarily decides he or she no longer wants to receive customer-directed services, the PCP will be revised to document the choice of agency-based services.

A customer may be involuntarily restricted from customer-directed services due to any of the following circumstances:
-The MA or the OA determines the customer and/or his or her representative have committed fraud regarding customer-directed program use of funds;
-The customer is living with a family member or other individual who has been determined by the Office of Inspector General (OIG), Adult Protective Services (APS) or other authorized entity (e.g., law enforcement) to have abused or neglected the customer or other individuals;
-The ISC agency and FMS have determined and documented the customer and/or his or her employer of record are not able to satisfactorily direct their own services, either with or without the assistance of an SDA provider; or
-The family/guardian has been found to be acting in his/her own interest rather than in the customer's best interest and there are no other guardians or representatives willing to assume this responsibility.

In cases of suspected fraud, abuse, neglect, or financial exploitation, the ISC agency helps customers file a complaint. The form used to file a complaint is the Rights of Individuals Form which can be located on the OA's website at http://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL462-1201.pdf .
This restriction of customer-directed services by the State is subject to appeal to the MA. The outcome of the appeal process is final. In this event, agency-directed services would be made available and documented in the PCP. The ISC works with the service providers, the SDA provider (if applicable) and the OA as necessary to ensure service continuity and health and welfare during the transition.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

(a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction:

During the level of care evaluation process, the local ISC entities under contract with the Operating Agency (OA) provide information about customer-directed opportunities and assist customers and their families in making informed choices from among waiver services.

Information is available for customers and their families that include guidelines for selecting personal support workers, information on financial management services, rights and responsibilities, and other requirements of the waiver. Information is also available on the OA's website located at https://www.dhs.state.il.us/page.aspx?item=32253. The ISC assist's the customer and their family to understand the service options available under the waiver. The information is reviewed with customers at least annually as part of the individual person-centered planning process.

Customers are given a handbook developed with input from families and other stakeholders that describes the benefits and potential liabilities of self-directed services. The Consumer Handbook for Home-Based services is found on the OA's website located at https://www.dhs.state.il.us/page.aspx?item=101181#a_toc16.

General customer responsibilities are referenced in Administrative Rule 89 IL Admin Rule 120.120. Additional customer responsibilities can be found on the OA's website and in the Consumer Handbook. Customer responsibilities include maintaining continuous Medicaid eligibility in order to continue receiving Home-Based Medicaid Waiver services and cooperating with determining their level of need for services. Customers must also manage their services effectively by educating themselves about program rules, procedures and forms. Customers need to familiarize themselves with the Consumer Handbook and any other documents related to their Personal Support Workers. Customers can educate themselves by accessing the list of resources located on the OA's website at https://www.dhs.state.il.us/page.aspx?item=93852. Customers must also manage their individual budgets wisely to avoid spending more than they are allocated. Maintaining communication with the ISC, Fiscal Agent, and providers is an essential responsibility for customers as well. Customers are also responsible for completing and submitting time sheets and other required paperwork on a timely basis. If a customer or their family/guardian feel they cannot uphold these responsibilities, they may request Self-Direction Assistance by contacting the ISC. Customers are also responsible for keeping the ISC agency updated on any significant changes in their life or with their needs. Reports must be immediately made if a customer:
-suffers an injury or death,
-is hospitalized for an unplanned reason,
-is lost or missing and the police have been contacted,
-is arrested, have legal charges or jailed,
-has experienced someone stealing from them or physically hurt them, or
-needs to be restrained.

(b) the entity or entities responsible for furnishing this information:

The ISC staff is the entity responsible for providing information to customer's on customer directed services. The customer receives information about customer-directed services and supports during the PCP process. Information is presented in both written and verbal formats to ensure the customer and family understand the customer-directed option and can make an informed choice. Information is provided about decision-making budget authority up to the approved level of support. Specific information is provided about the roles and responsibilities of the parent or legal representative and the financial management services.

A Self-Direction Assistant (SDA) is also available to assist the customer (or the customer's family/representative, as appropriate) in arranging for, directing and managing services. Practical skills training is offered to enable families and customers to independently direct and manage waiver services. Examples of skills training include providing information on recruiting and hiring personal support workers, managing workers, and providing information on effective communication and problem-solving. The service/function includes providing information to ensure customers understand the responsibilities involved with directing their services.

(c) how and when this information is provided on a timely basis:

Information on customer directed services is provided upon initial assessment, at each reassessment, and any time the PCP is reviewed and amended.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Occupational Therapy (Extended Medicaid State Plan)	☐	☒
Personal Support	☒	☒
Skilled Nursing	☐	☒
Vehicle Modification	☐	☒
Speech Therapy (Extended Medicaid State Plan)	☐	☒
Behavioral Services (Psychotherapy and Counseling)	☐	☒
Home Accessibility Modifications	☐	☒
Behavior Intervention and Treatment	☐	☒
Training and Counseling Services for Unpaid Caregivers	☐	☒
Non-Medical Transportation	☐	☒
Physical Therapy (Extended Medicaid State Plan)	☐	☒
Assistive Technology	☐	☒
Temporary Assistance	☒	☒
Adaptive Equipment	☐	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The State conducted a Request for Proposal (RFP) process to select Financial Management Service (FMS) vendor(s). The Operating Agency (OA) developed the RFP for the FMS Vendor Fiscal option pursuant to Section 3504 of the IRS Code, IRS Revenue Procedure 70-6, and IRS Proposed Notice 2003-70m as well as OA rules and regulations.

The criteria used in selecting the vendor(s) included:
-Financial stability, with at least one year of experience in providing employer agent services to customers in similar customer-directed options.
-Ability to perform all functions in accordance with Federal, State and Department regulations and requirements.
-Ability to perform all functions directly without the use of a sub-agent.
-Ability to verify, process and pay invoices for goods and services approved in the customer's PCP in accordance with OA requirements.
-Ability to prepare and maintain a comprehensive FMS policy and procedure manual that reflects all tasks performed, Illinois-specific labor, tax and workers' compensation insurance requirements, as well as requirements of the waiver.
-An internal quality management plan that demonstrates sufficient internal controls to monitor FMS performance.

The OA contracts with Avenues to Consumer Employer Services and $supports (ACES$) to provide FMS services in Illinois. ACES$ handles Personal Support Worker (PSW) pre-employment testing, new hire paperwork and payroll/tax functions. If a customer chooses to hire their own PSWs, they must use ACES$.

There is no charge to a customer's monthly budget for the FMS.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The per member per month (PMPM) fee paid to the FMS private entities is established through the RFP competitive bid process. As of July 1, 2021, the fee is $73 PMPM as agreed upon in the contract between the FMS entity and OA. This is a reasonable amount based on the scope of services specified in E-1-i-iii.

The PMPM fee for waiver customers is negotiated between the State and the successful bidder(s). The FMS entity bills for services through the OA's Reporting of Community Services (ROCS) billing system. The fee is claimed as an administrative fee under the waiver by the Medicaid Agency.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☒ **Other**

Specify:

Assist with performing required background checks, abuse and neglect registry checks and any other required screenings. Verify independent Personal Support (domestic employee) provider qualifications, conducts pre-employment testing, new hire paperwork and payroll/tax functions. These functions are necessary for the proper and efficient administration of the waiver by reviewing and ensuring provider qualifications are met.

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**

- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [ ] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

(a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform:

The FMS private entity(ies) must have internal monitoring procedures and processes to ensure contract performance compliance. The State reserves the right to monitor and track vendor performance over the course of the contract.

(b) The entity (or entities) responsible for this monitoring:

The OA will monitor the vendor(s) based on the performance measures approved in the waiver and any other contractual requirements. The vendor(s) agrees to provide all of the data specified by the State for service payment and claiming purposes. The vendor(s) agrees to cooperate with the State on monitoring and tracking activities which may require the vendor to submit requested progress reports, allow unannounced inspections of its facilities, participate in scheduled meetings and provide management reports as requested by the State.

(c) How frequently performance is assessed:

The OA reviews performance on an annual basis. The results of these reviews are shared with the Waiver Quality Management Committee during the quarterly meetings. The review is conducted remotely, and the review includes the date of hire, required background checks, and any required training. If deficiencies are noted, the FMS entity must submit a plan of correction in 10 days have the correction or remediation completed within 30 days.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☒ **Waiver Service Coverage.**
Information and assistance in support of
participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Occupational Therapy (Extended Medicaid State Plan)	☐
24-Hour Stabilization Services	☐
Supported Employment - Individual Employment Support	☐
Adult Day Service	☐
Personal Support	☐
Skilled Nursing	☐
Vehicle Modification	☐
Speech Therapy (Extended Medicaid State Plan)	☐
Residential Habilitation	☐
Behavioral Services (Psychotherapy and Counseling)	☐
Home Accessibility Modifications	☐
Supported Employment – Small Group Supports	☐
Remote Support	☐
Behavior Intervention and Treatment	☐
Training and Counseling Services for Unpaid Caregivers	☐
Non-Medical Transportation	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Physical Therapy (Extended Medicaid State Plan)	☐
Self Direction Assistance	☒
Community Day Services	☐
Assistive Technology	☐
Emergency Home Response Services (EHRS)	☐
Temporary Assistance	☐
Adaptive Equipment	☐

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

(a) The types of entities that furnish these supports;
ISC agencies, under contract with the Operating Agency (OA), are compensated through a per customer allocation that is standard statewide.

One or more Financial Management Service (FMS) entity/entities, under contract with the OA, are compensated on a per member per month basis.

(b) How the supports are procured and compensated;
ISC's were selected through a request-for-proposal (RFP) process. ISC agencies are compensated through a per customer allocation that is standard statewide.

FMS entity/entities are selected through a request for proposal process. Financial Management Service (FMS) entity/entities are compensated on a per member per month basis.

(c) Describe in detail the supports that are furnished for each participant direction opportunity under the waiver;

ISC's conduct assessments, develop the person centered plans (PCP) with the customers, assist with linkage and applications for any non-Waiver services, inform customers of all willing and qualified providers, complete any necessary prior approval applications, ensure PCPs are implemented, provide necessary coordination of services, explain and provide information about reporting abuse/neglect/exploitation, and explain appeal rights and assist in filing appeals as needed.

FMS provides fiscal agent and employer agency services.

(d) The methods and frequency of assessing the performance of the entities that furnish these supports;
Annually the OA conducts site visits at all ISC entities and reviews their performance using a representative sample of all waiver participants.

(e) The entity or entities responsible for assessing performance;
The OA reviews the performance of the ISCs and FMS entity/entitites on an annual basis.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

A customer or their guardian, if one has been appointed, may choose to voluntarily terminate from customer-direction at any time by contacting the ISC and requesting a change to their person-centered plan (PCP). If the customer exercised employer authority, employees of the customer are typically provided with 30 days advance written notice of the termination, however, this notification is not mandatory. The customer selects a community agency to provide and direct needed waiver services. These changes are discussed among those responsible for person-centered planning. The PCP is updated to reflect the change in the service delivery method, the customer's or guardian's (when applicable) decision to terminate customer-direction, and the selected community agency(ies) that will now be delivering services. The ISC works with service providers and the OA as necessary to ensure service continuity and the health, safety and welfare of the customer during the transition.

If the health, safety and welfare of the customer cannot be assured on a long-term basis within the cost limit of customer-directed supports in combination with other natural supports and community resources, the customer will be considered for other service options within the waiver, including other residential habilitation options. The cost limits were established through a review of historical expenditures. The cost limits are set in statute.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

A customer may be involuntarily restricted from customer-directed services due to any of the following circumstances:

-The MA or the OA determines the customer and/or his or her representative have committed fraud regarding customer-directed program funds;
-The customer is living with a family member or other individual who has been determined by the Office of Inspector General (OIG), Adult Protective Services (APS), or other authorized entity (e.g., law enforcement) to have abused or neglected the customer or other individuals;
-The ISC agency and FMS have determined and documented the customer and/or his or her employer of record are not able to direct their own services, either with or without the assistance of an SDA provider; or
-Family/guardian has been found to be acting in his/her own interest rather than in the customer's best interests and no other guardian or representative is willing to take on this responsibility.

In cases of suspected fraud, abuse, neglect, or financial exploitation, the ISC agency can assist the customer in filing a complaint. The form used is the Rights of Individuals Form which can be accessed at: http://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL462-1201.pdf.

This restriction or termination of customer-directed services by the OA is an appealable decision. The customer may appeal the decision to involuntarily terminate their customer-directed services to the MA. ISC's inform customers of their rights to appeal initially upon enrollment, annually as part of the person-centered planning process and more often as needed. Customers can also access information on their rights to appeal on the OA's website located at http://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL462-1202.pdf. Printed information on appeals can also be presented to the customer upon request. The outcome of the appeal process by the MA hearing officer is final. In this event, agency-directed services would be made available to the customer and the customer's decision whether to accept agency-directed services would be documented in the PCP. The ISC works with the service providers, SDA provider (if applicable) and the OA as necessary to ensure service continuity and health, safety and welfare of the customer during the transition from the customer-directed service model to the agency-directed service model.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		9700
Year 2		10200
Year 3		10700
Year 4		11200
Year 5		11700

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer

(managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☐ **Select staff from worker registry**
☒ **Hire staff common law employer**
☒ **Verify staff qualifications**
☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Cost of required background checks are paid through the Financial Management Service entity.

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☒ **Determine staff wages and benefits subject to state limits**
☒ **Schedule staff**
☒ **Orient and instruct staff in duties**
☒ **Supervise staff**
☒ **Evaluate staff performance**
☒ **Verify time worked by staff and approve time sheets**
☒ **Discharge staff (common law employer)**
☐ **Discharge staff from providing services (co-employer)**
☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☒ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the state's established limits**
- ☒ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☒ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Within the overall home-based supports cost limit, the person-centered plan (PCP) specifies the types of and amounts of covered services needed by the customer. For home-based supports, the maximum annual allocation is set by State law. At the time the law was passed, public hearings were held regarding its implementation. The annual allocation is tied to Social Security benefit levels which are indexed to the cost of living (as required by law). The allocation is reviewed annually by the Operating Agency (OA) and the Medicaid Agency (MA).

Customers and the general public are made aware of the program budget allocation amounts in a variety of ways. For example, the program Waiver Manual is available at the OA's website and contains information on the budget allocations. A Rate Table is also posted on the OA's website which outlines statewide rates for certain services. In addition, ISC's and SDA providers (if applicable) assist customers in understanding and working within the annual and monthly cost allocations.

For some services, statewide rates apply, such as Behavior Intervention and Treatment. For other services, the customer is given the authority to negotiate individual rates. A written Service Agreement is executed between each service provider, the customer or his or her guardian and the SDA provider (if applicable). The Service Agreement defines the terms of the services to be provided including the effective date, the rate of payment, the maximum units of service to be provided each month and the maximum monthly charge. A copy of the Service Authorization for domestic employees is on file with the Financial Management Service (FMS) entity. Bills submitted in excess of the monthly and annual allocations are rejected for payment. This ensures the combination of services received is consistent with the PCP and does not exceed the annual service cost limit.

The OA Rate Table is reviewed annually by the OA and MA and it is updated when rate adjustments are implemented, based on State appropriations.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Upon being authorized for waiver services, the customer or guardian (when applicable) is informed in writing by the OA and in person by the ISC about the overall cost allocation limit, customer-directed opportunities, and budget authority. Once services have begun, the customer or guardian (when applicable) is notified and kept informed of any adjustments to the overall allocation amount by the OA and ISC. The customer and guardian (when applicable) work with the ISC to establish a budget as a part of the customer’s PCP. Adjustments to the budget and/or the PCP can be made throughout the year as needed or requested by the customer. When a customer’s needs change, the customer works with the ISC to adjust the PCP and works with the providers to adjust the Implementation Strategies. Service Agreements are developed based on the service needs identified in Implementation Strategies.

A Service Agreement form is completed annually to detail the customer’s budget. This form may be modified throughout the course of the year as needed.

This form is available upon request from the OA. Should any services be reduced or denied, the customer is notified of their right to appeal.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**

◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Customers and guardians, when applicable, may adjust PCPs within the monthly or annual cost allocation without prior review or approval by the OA. Adjustments are made via the use of Service Agreements with providers and by updating the PCP. Changes in services are documented in the PCP and in revised Service Agreements. Changes in Service Agreements where the customer exercises budget authority are shared with the ISC for monitoring purposes. Changes in Service Agreements where the customer exercises employer authority are shared with the Financial Management Service (FMS) entity when services provided by domestic employees change. Prior review by the OA is only required when services are requested which normally require Prior Approval by the OA.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Per the Developmental Disability and Mental Disability Services Act (405 ILCS 80), adult's home-based supports spending is limited on a monthly basis. The service agreement states the provider, the reimbursement rate, and the amount of services authorized for the month. Customers are encouraged by members of the person-centered planning team and SDA providers (if applicable) to allocate authorized services throughout the entire month to avoid premature depletion of program funds.

Edits in the electronic billing system prevent over expenditures on monthly spending. The OA's electronic transfer alerts the FMS of any units of service above the authorized services. Any provider billings that exceed the monthly allotment of services are rejected and remain unpaid.

The ISC is responsible for monitoring PCP implementation and customer health, safety and welfare, identify and address issues of concern, including the timely prevention of the premature depletion of the customer-directed budget or potential service delivery problems. The minimum frequency of contact for monitoring the PCP's implementation, including direct, in-person contact with the customer, is at least four times a year. This four times a year monitoring visit includes the direct contact for PCP development.

The ISC (on a mid-year basis) reviews that the PCP is being fully implemented. Also, the OA, on a statistically valid sample basis, reviews that the PCP is being fully implemented.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Notification

Any customer who applies for or receives waiver services has the right to appeal adverse decisions and actions. ISC entities are responsible for informing customers of their right to appeal. The customer is informed by the ISC of his/her right to appeal adverse actions taken regarding services or eligibility. In addition, the customer is informed of their rights at the time of the initial home visit and upon every reassessment. The right to appeal is also covered on the OA's website located at https://www.dhs.state.il.us/page.aspx?item=101181#a_toc8. Customer appeal rights are also outlined in 59 Ill. Admin. Code 120.110.

The OA has developed a standard form, Notice of Individual's Right to Appeal Medicaid Waiver Determinations (IL462-1202, in English and Spanish) for customers to use when filing an appeal. This form is located on the OA's website at http://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL462-1202.pdf.

The ISC, OA or provider agency, whichever entity took the adverse decision or action, will notify the customer and/or guardian in writing of the action taken and the process to appeal. The customer and/or guardian will be provided with a notice that includes the action, whether or not services will continue and a copy of the Notice of Individual's Right to Appeal Medicaid Waiver Determinations (IL462-1202). This written notice serves as the notice of the right to appeal for the customer and begins the 10-business day timeframe for the customer to provide written notification to the ISC of their intent to appeal. The customer's services will remain in place at the former levels pending the final decision of the appeal.

OA staff and MA staff are responsible for written notification when there is an adverse decision in the fair hearing process. The OA staff provide written notification during the informal review process. The MA staff provide written notification during the administrative hearing process.

Appeal Process

Customers and guardians, if appointed, are informed by the ISC of appeal rights when services are presented including the choice of HCBS as an alternative to institutional care, denying the service or the providers(s) of their choice and also upon notice of service denial, suspension, termination or reduction.

Information about appeal rights is also available at any time upon request. 89 Ill. Admin. Code 104 and 59 Ill. Admin Code 120.110 describes the fair hearing request procedures in use for the Adult Developmental Disability Waiver.

Copies of notices are maintained in the customer's record by the ISC. If customers receive notice of adverse action, they have ten working days to file written notification to the ISC of their intent to appeal. The ISC must submit the appeal packet to the OA within 60 calendar days of the date the customer receives the notice of adverse decision or action. The request for an appeal allows the customer's services to remain in place at the former levels until a final hearing decision is reached or until the appeal is withdrawn.

Once the appeal is filed, the OA has 30 working days to conduct an informal review of the appealed action. The informal review process can reverse, modify, or leave the action unchanged. At the conclusion of the informal review, the customer, and the service provider, if applicable, is notified in writing of the OA's decision within ten working days after the informal review. The written notice includes clear statements of the action to be taken, the reason for the action, supporting policy references, and a complete statement of the customer's right to appeal the decision to the MA. If the customer agrees with the OA's informal review decision, the customer may withdraw their appeal.

If the customer does not agree with the OA's decision through the informal review, the customer has ten working days to appeal the informal review decision and request a formal appeal hearing with the MA for final administrative action. The MA's fair hearings process is the same for all customers. The MA is the final level of Appeal. An MA Hearing Officer conducts the formal hearing. At the hearing, the customer can present evidence on his/her behalf to dispute the adverse action. The customer may choose to be represented by legal counsel or another person the customer appoints. The decision of the formal hearing is made by the Medicaid Director and is final and can only be appealed through the circuit court system.

The MA appoints an impartial hearing officer to conduct the hearing at the MA or OA office nearest to the customer's home unless all parties agree to an alternate location. All parties may participate by phone or video conference.

The Medicaid hearing officer conducts the formal appeal, drafts the decision and sends it to the MA Hearing Supervisor for final review and sign-off by the Medicaid Director. Once a final decision is released by the MA, it is reviewable only through the Circuit Courts of the State of Illinois.

The MA rule (89 Ill. Adm. Code 104.70) provides that an appeal decision shall be given within 60 days of the date it was filed unless additional time is required, which may include postponement or continuance of a hearing for good cause as provided in 89 Ill. Adm. Code 104.45. The appeal process follows federally mandated rules that require all appeals to be treated equally and ensure due process is given for each appellant.

Training for the Medicaid hearing officers is conducted in several ways: by group training, one-on-one mentoring, and shadowing of experienced Medicaid hearing officers. Training encompasses the Medicaid Hearing Officer Manual, and the Medicaid waiver administrative codes and citations. All current HFS Medicaid Hearing Officers have experience in HFS programs, either Medical Programs or Child Support. Monitoring of the hearing process and final decisions occurs in several ways:
- The scheduling Medicaid Hearing Officer Supervisor creates a monthly report with the disposition of all cases to assure that hearings are being scheduled and moving through the process.
- Decisions go through three levels of HFS review:
o the Medicaid Hearing Officer drafts the case
o the Medicaid Hearing Supervisor reviews 100% of the cases
o the Medicaid Director makes the final decision on every case
- Quality Controls consist of reviewing cases for consistency in the application of the Medicaid laws and the use of sound legal reasoning. Trends and patterns are also considered as part of the quality oversight process.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The OA is responsible for the grievance/complaint system.

The ISC entities, under contract with the OA, are responsible for hearing and resolving issues that arise at the local providers. The OA is responsible for providing technical assistance when the ISC entities cannot successfully resolve local issues. The OA maintains a database of complaints referred by ISCs or made directly by customers. Reports from the database are shared monthly by the OA with the MA. The data is analyzed and evaluated for trends on a quarterly and annual basis. As individual problems and trends are identified, proactive remediation is initiated. The State establishes remediation plans by identifying the responsibilities of the MA and OA and identifying timeframes for completion. The Waiver Quality Management Committee collectively tracks the remediation activity.

The FMS entity/entities maintains a complaint log regarding issues concerning the payment of domestic employees. Summary data from the log is reported to and reviewed by the OA on a quarterly basis. This information is shared with and reviewed by the Quality Management Committee on an annual basis. Remediation is initiated and tracked as necessary. The State establishes remediation plans by identifying the responsibilities of the MA and OA and identifying timeframes for completion.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) the types of grievances/complaints that participants may register

Upon enrollment and at each reassessment thereafter, customers and guardians are informed by the ISC of the OA's informal grievance process for making complaints, and that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing. The OA's procedures do not require customers to file an informal grievance prior to exercising their right to appeal. Customers who are dissatisfied with some aspect of service provision may contact the ISC to file grievances or complaints. The ISCs use the Rights of the Individuals form (IL462-1201), found here https://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL462-1201.pdf, to document the notification. Options for filing complaints are also posted on the OA's website located at https://www.dhs.state.il.us/page.aspx?item=52240.

The type of complaints can include anything of concern to the customer or guardian, e.g., dissatisfaction with the customer's PCP, failure to implement the customer's PCP, quality of services or supports, risk of losing services, etc. In addition, customers can identify and report issues that are program-wide and do not specifically apply to their individual services.

(b) the process and timelines for addressing grievances/complaints

Customers have 30 days to file a complaint/grievance after the incident occurs. When a complaint is received, the OA will make an initial response to the customer making the complaint within two business days to let them know the complaint was received and is being reviewed. The OA has an overall goal to resolve grievances within 30 days. Timeliness is tracked and monitored by the OA and reported and discussed with the MA at the quarterly Waiver Quality Management meetings.

Upon receipt of a complaint, the OA records the complaint in a database that documents the person making the complaint; the type of complaint; the substance of the complaint; the names of any customers, providers, and/or ISC's involved; the person(s) at the OA assigned to review and address the complaint; action steps taken; final resolution; and dates of intake, action steps, and resolution.

(c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency

An OA staff person is assigned to each complaint. The assigned staff person confirms and/or collects information from the ISC, provider(s), and any other parties involved. He or she then takes appropriate action steps depending upon the complaint. Action steps include follow up with the individual submitting the grievance/complaint, waiver customer, provider agency, ISC, etc. to determine cause of the grievance and work with these entities to find a suitable resolution for all parties. Final resolution is recorded in the log. Reports are produced twice monthly for managers within the OA to ensure open complaints are being addressed on a timely basis.

The data is analyzed and evaluated for trends on a quarterly and annual basis. The summary reports are shared with the MA at the quarterly Waiver Quality Management meetings. As individual problems and trends are identified, proactive remediation is initiated. Based on the data, the OA and MA may develop system improvement plans by identifying the responsibilities of the MA and OA and identifying time frames for completion. The Waiver Quality Management Committee (QMC) tracks all system improvement plans until completion.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The OA has two network-wide reporting structures for tracking and following-up on critical incidents. The first structure covers, all alleged instances of abuse, neglect, self-neglect, or exploitation (ANE) that are reported to either the State's Office of Inspector General (OIG) or the State's Adult Protective Services (APS) entity depending on which setting the customer receives services. The second reporting structure is the Critical Incident Reporting and Analysis System (CIRAS).

The State requires the reporting of alleged abuse, neglect, exploitation, and unanticipated deaths of customers receiving services in settings that are licensed or certified by the Bureau of Accreditation, Licensure, and Certification (BALC), or funded by the OA. These allegations are reported to the OIG for intake and investigation. Reports can be made by anyone having contact with the customer or otherwise aware of the allegations. Employees within Independent Service Coordination (ISC) agencies and providers are mandated to report allegations. Reports are made via phone calls to the OIG hotline: (800) 368-1463.

For customers receiving supports in settings licensed or certified by BALC, the OA uses a set of definitions for critical incidents covering abuse, neglect, self-neglect or exploitation and other events that can place an individual at risk which are found at 59 Ill. Adm. Code 50, Section 50.10.
-Abuse. See definitions for physical abuse, sexual abuse, mental abuse and financial exploitation.
-Egregious neglect. A finding of neglect as determined by the Inspector General that represents a gross failure to adequately provide for, or a callous indifference to, the health, safety or medical needs of a customer and results in an customer's death or other serious deterioration of an customer's physical condition or mental condition.
-Financial exploitation. Taking unjust advantage of a customer's assets, property or financial resources through deception, intimidation or conversion for the employee's, facility's or agency's own advantage or benefit.
-Mental abuse. The use of demeaning, intimidating or threatening words, signs, gestures or other actions by an employee about a customer and in the presence of a customer or customers that results in emotional distress or maladaptive behavior, or could have resulted in emotional distress or maladaptive behavior, for any customer present.
-Neglect. An employee's, agency's or facility's failure to provide adequate medical care, personal care or maintenance, and that, as a consequence, causes a customer pain, injury or emotional distress, results in either a customer's maladaptive behavior or the deterioration of a customer's physical condition or mental condition, or places a customer's health or safety at substantial risk of possible injury, harm or death.
-Physical abuse. An employee's non-accidental and inappropriate contact with a customer that causes bodily harm. "Physical abuse" includes actions that cause bodily harm as a result of an employee/facility/agency directing a customer or person to physically abuse another customer.
-Sexual abuse. Any sexual contact or intimate physical contact between an employee and a customer, including an employee's coercion or encouragement of a customer to engage in sexual behavior that results in sexual contact, intimate physical contact, sexual behavior, or intimate physical behavior. Sexual abuse also includes:
o an employee's actions that result in the sending or showing of sexually explicit images to a customer via computer, cellular phone, electronic mail, portable electronic device, or other media, with or without contact with the customer; or
o an employee's posting of sexually explicit images of a customer online or elsewhere, whether or not there is contact with the customer. Sexual abuse does not include allowing customers to, of their volition, view movies or images of a sexual nature or read text containing sexual content unless the customer's guardian prohibits the viewing of those movies or images or reading of that material.

See 89 Ill. Adm. Code 270 at http://ilga.gov/commission/jcar/admincode/089/08900270sections.html.

Under this regulation, "If any mandated reporter has reason to believe that an eligible adult, who because of disability or other condition or impairment is unable to seek assistance for himself or herself, has, within the previous 12 months, been subjected to abuse, neglect, or financial exploitation, the mandated reporter, shall, within 24 hours after developing such belief, report this suspicion…" [Quoted from enabling statute: 320 ILCS 20/4(a-5).]
Under this regulation, unanticipated deaths must be reported within 24 hours from the time the death was first discovered, or the reporter was informed of the unanticipated death or within four hours if abuse or neglect is suspected. Required reporters must report allegations of abuse, neglect, or exploitation within four hours of initial discovery by the required reporter.

The State also requires the reporting of alleged abuse, neglect, and exploitation of customers receiving supports in their own homes. These reports are sent to the State's Adult Protective Services (APS) unit for review and actions necessary to ensure the health and safety of the alleged victim. Reports can be made by anyone having contact with the customer or otherwise aware of the allegations. Employees within ISC agencies and providers are mandated reporters. The Adult

Protective Services Act (320 ILCS 20/1 et seq.) authorized the Illinois Department on Aging (IDoA) to administer the Adult Protective Services (APS) Program to respond to reports of community-based abuse, neglect, self-neglect, or exploitation. The empowered APS Program provides for intake, investigation, and follow-up of reported incidents. The APS Program is coordinated through 39 agencies located throughout the state and designated by the Area Agencies on Aging (AAA) and the Illinois Department on Aging. APS agencies conduct investigations and work with adults age 60 or older and adults age 18-59 with disabilities (including those covered by the waiver), in resolving the abuse, neglect, self-neglect, or financial exploitation. Persons can report suspected abuse, neglect, self-neglect, or exploitation by utilizing the APS Hotline number at 1-866-800-1409, available 24 hours a day, seven days a week. They may also call the Senior Helpline at 1-800-252-8966 (voice) or 888-206-1327 (TTY).

Definitions of ANE for customers receiving supports in their own homes.

For these customers, the OA uses a set of definitions for critical incidents covering abuse, neglect, self-neglect or exploitation and other events that can place a customer at risk which are found at 89 Ill. Adm. Code 270, Section 270.210.
-Abuse means causing any physical, mental, or sexual injury to an eligible adult, including exploitation of such adult's financial resources [320 ILCS 20/2(a)].
-Neglect means another individual's failure to provide an eligible adult with or willful withholding from an eligible adult the necessities of life including, but not limited to, food, clothing, shelter or health care. This definition does not create any new affirmative duty to provide support to eligible adults. Nothing in the Act shall be construed to mean that an eligible adult is a victim of neglect because of health care services provided or not provided by licensed health care professionals [320 ILCS 20/2(g)].
-Physical abuse means the causing of physical pain or injury to an eligible adult.
-Sexual exploitation means any sexual activity with an eligible adult who is unable to understand, unwilling to consent, threatened, or physically forced to engage in such sexual activity.
-Emotional abuse means verbal assaults, threats of maltreatment, harassment, or intimidation.
-Confinement means restraining or isolating an individual for other than bona fide medical reasons.
-Passive neglect means the failure by a caregiver to provide an eligible adult with the necessities of life including, but not limited to, food, clothing, shelter, or medical care, because of failure to understand the eligible adult's needs, lack of awareness of services to help meet needs, or a lack of capacity to care for the eligible adult.
-Willful deprivation means the deliberate denial to an eligible adult of required medication, medical care, shelter, food, therapeutic devices, or other physical assistance, thereby exposing that person to the risk of physical, mental, or emotional harm. Willful deprivation shall not include the discontinuation of medical care or treatment when the eligible adult has expressed a desire to forego such medical care or treatment.
-Financial exploitation means the use of an eligible adult's resources by another to the disadvantage of that adult or the profit or advantage of a person other than that adult [320 ILCS 20/2(f-1)].

The Illinois Adult Protective Services Act (320 ILCS 20/1) requires personnel of the Area Agencies on Aging, the OA, the ISCs, and provider agencies to be mandated reporters in cases where the adult is unable to self-report. The APS policy specifically states that if a direct service worker witnesses or identifies a case of possible abuse, neglect, self-neglect, or financial exploitation, they are mandated to personally report the allegations to the designated APS agency or to the OA's Hotline number within 24 hours. State regulations covering APS mandated reporters and timelines for reporting are contained in 89 Illinois Administrative Code (ILAC), Part 270.30.

Follow-up Actions by the APS can be found at: 89 ILAC, Section 270.240 Intake of ANE or Self-Neglect Reports.

APS rules may be accessed at the IDoA's website at:
https://www2.illinois.gov/aging/AboutUs/Pages/rules-main.aspx

In addition, the state requires the reporting of other critical incidents to the OA through its automated Critical Incident Reporting and Analysis System (CIRAS). The other critical incidents include deaths otherwise not reportable to OIG or APS, known injuries, law enforcement involvement, medical emergencies, missing customers, peer-to-peer acts of aggression, unauthorized restraint, injuries of unknown origin, and unscheduled hospitalizations. Providers must report such incidents within two working days of discovery or being informed of the incident. Since the incidents reported through CIRAS do not involve allegations of abuse, neglect, or exploitation, providers are given more time to compile and report information ensuring it is complete and accurate for trend analysis. The manual for the CIRAS system is available from the OA's website located at https://www.dhs.state.il.us/page.aspx?item=97101.

Upon entry of an incident into CIRAS, the electronic system automatically notifies the ISC agency of the report. ISCs use this information to effectively monitor the customer's well-being and ensure any needed actions are taken. The ISC staff review the critical incidents in a timely manner, actively attempt to mitigate risk(s) associated with their occurrence while implementing risk-mitigation strategies aimed at reducing future critical incidents. OA staff also receives notification upon entry of reports of missing person and law enforcement involvement. All types of reports are summarized and analyzed on a monthly basis by OA staff. The summary and analytical reports are shared with the MA on a quarterly basis at the Waiver Quality Management meetings.

ISCs must comply with the 59 Ill. Adm. Code Part 50, Elder Abuse and Neglect Act, and the Critical Incident reporting requirements of the OA. ISCs must comply with all health, safety, and welfare monitoring and reporting required by State or federal statute or regulation, or that is a condition for a HCBS Waiver, including the following: critical-incident reporting regarding abuse, neglect, self-neglect, and exploitation; critical-incident reporting regarding any incident that has the potential to place a customer, or a customer's services, at risk, but which does not rise to the level of abuse, neglect, or exploitation; and performance measures relating to the areas of health, safety, and welfare and required for operating and maintaining an HCBS Waiver.

Examples of critical events may include but are not limited to:
- 911 Call
- Death
- Unknown Injury
- Law Enforcement
- Medical Emergency
- Missing Individual
- Peer to Peer Acts
- Peer to Staff
- Unauthorized Restraint
- Unknown Injury
- Unscheduled Hospitalization

For these types of incidents, if there is a perceived immediate threat to a customer's life or safety, the ISC and/or provider will follow emergency procedures which may include calling 911.

All incidents will be entered into CIRAS and reported to the OA. Based on the situation, the customer's age or placement reports will also be made to the appropriate State of Illinois investigative agencies.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Customers and/or their guardian (if one has been appointed) are informed by the ISC about protections from abuse, neglect, and financial exploitation (ANE).

The information provided includes the process for reporting allegations to the Office of the Inspector General (OIG) for those customers receiving services in settings that are licensed or certified by the Bureau of Accreditation, Licensure, and Certification (BALC) or funded by the OA, and to the Adult Protective Services (APS) for those customers receiving services while residing in their own homes. Customers and guardians are informed that anyone who suspects abuse, neglect or financial exploitation may report an allegation.

Information is provided in the Rights of the Individual form (IL462-1201), located at https://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL462-1201.pdf, and is shared with the Customer and guardian (if one has been appointed) upon enrollment and upon every reassessment thereafter. ISC staff discuss the importance of reporting allegations of abuse, neglect and financial exploitation and other critical incidents.

Information on the State's hotline is available on multiple websites and is also listed in the Waiver Manual, located at https://www.dhs.state.il.us/page.aspx?item=45227. Instructions about reporting allegations, including the hotline, are also available on the OA website, located at https://www.dhs.state.il.us/page.aspx?item=52240. The State addressed the need for public awareness through campaigns, such as “Break the Silence” and "Engage to Change". These public awareness campaigns, facilitated through the Adult Protective Services at Illinois Department on Aging, provide information and training about how to prevent, recognize, and report situations involving abuse, neglect, self-neglect, and exploitation of all adults. The State developed a brochure for all HCBS waiver customers and family members/guardians that explains how to report ANE.

The OA monitors and ensures customers and guardians have received appropriate information about reporting allegations of abuse, neglect and financial exploitation.

ISC staff receive training on critical incident reporting and follow-up. Direct care staff are provided training through their employer and new state provider standards have enhanced requirements for staff training about abuse, neglect, self-neglect, exploitation, and mandated reporting requirements.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Allegations of Abuse, Neglect, or Exploitation in Settings Licensed or Certified by the Bureau of Accreditation, Licensure, and Certification (BALC) or funded by the OA.

The State's Office of Inspector General (OIG), which is a semi-independent entity that reports to both the Governor and the Secretary of IDHS, has statutory authority to receive and investigate reports of alleged abuse, neglect and exploitation of adults with developmental disabilities served in settings licensed or certified by BALC or funded by the OA.

OIG staff receiving the report of the allegation are responsible for assessing, based on the information received at intake, whether the allegation could constitute abuse, neglect or exploitation and whether OIG has the authority to investigate. OIG must make these assessments within one day after receiving the report.

Any allegations or investigations of reports of abuse, neglect and exploitation shall remain confidential until a final report is completed. The identity of any person as a complainant shall remain confidential in accordance with the State's Freedom of Information Act [5 ILCS 140] or unless identification is authorized by the complainant. Information concerning tests for human immunodeficiency virus (HIV) and diagnosis and treatment for acquired immune deficiency syndrome (AIDS) shall be disclosed to OIG by community agencies only in accordance with the AIDS Confidentiality Act [410 ILCS 305]. All personal health related information contained in OIG investigative reports shall remain confidential in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191) (45 CFR 160, 162 and 164).

All investigations shall be conducted in a manner that respects the dignity and human rights of all persons involved.

After determining the finding in all cases, the OIG must notify the following parties of the finding:
-the complainant,
-the customer who was allegedly abused, neglected or exploited or his or her legal guardian (if applicable);
-the person alleged to have committed the offense; and
-the employer of the person alleged to have committed the offense (i.e., the qualified service provider).

Within 10 days of completion, copies of investigative reports are shared with the State's Human Rights Authority, the protection and advocacy organization (Equip for Equality), the OA, and BALC.

If an investigation results in a substantiated finding of physical abuse, sexual abuse, egregious neglect or financial exploitation, it shall result in the accused employee's identity and the OIG finding being reported to the Health Care Worker Registry.

Allegations of Abuse, Neglect, or Exploitation in Settings Not Licensed or Certified by BALC.

The State's Adult Protective Services (APS) agency operated at the Illinois Department on Aging (IDoA) has statutory authority to receive and investigate all allegations of abuse, neglect, and financial exploitation of adults aged 18 and over in private homes. APS investigates allegations, assesses the customer's situation and circumstances, takes emergency actions as needed, and works with local law enforcement authorities when necessary.

The State has established classifications for critical incidents (i.e., Priority I, II, III,) depending upon the nature and urgency of the event. This classification determines whether an investigation needs to occur and the timeframe for conducting that investigation. The definitions and time frames of these levels are located at 89 ILAC Section 270.240 located at http://ilga.gov/commission/jcar/admincode/089/089002700C02400R.html.

Depending on the nature and seriousness of the allegations, and the priority level given to the report, a trained APS caseworker makes a face-to-face contact with the alleged victim with the following time frames:
-Priority one reports are reports of abuse or neglect in which the alleged victim is reported as being in serious physical harm or in immediate danger of death or serious physical harm. Priority one reports include, but are not limited to, alleged abuse resulting in fractures, head injuries, internal injuries, or burns; threats of serious injury or death; lack of basic physical necessities severe enough to result in freezing, serious heat stress or starvation; need for immediate, significant medical attention; and alleged sexual abuse that has occurred in the last 72 hours. The APS caseworker must make a face-to-face visit within 24 hours of receipt of the report.
-Priority two reports are reports of abuse, neglect or exploitation in which the alleged victim is reported as being abused, neglected or exploited and the report taker has reason to believe that the health and safety consequences to the alleged

victim are less serious than priority one reports. Priority two reports include, but are not limited to, physical abuse involving scratches or bruises; inadequate attention to physical needs such as insufficient food or medicine; unreasonable confinement; and probability of liquidation or depletion of an alleged victim's income and assets. The APS caseworker must make a face-to-face visit within 72 hours of receipt of the report.
-Priority three reports are reports of abuse, neglect or exploitation in which the alleged victim is reported as being emotionally abused or the alleged victim's financial resources are being misused or withheld and the report taker has reason to believe that there is no immediate or serious threat of harm to the alleged victim. The APS caseworker must make a face-to-face visit within 7 calendar days of receipt of the report.
The State requires that all reports are investigated with initial contact based on assigned priority. APS investigates all reports and with consent, will put interventions in place to address the health, safety, and welfare of the alleged victim. The State's Office of Adult Protective Services' regulations also require certain response timelines by the ANE agency.

A trained Adult Protective Services case worker, trained by the Illinois Department on Aging, will respond within the specified time period depending on the severity of the case and begin the investigation if consent is given.

As an adult, a competent person may exercise their consent authority to accept or refuse an assessment and may accept or refuse all services and interventions offered during the review and resolution of the allegation. This is called the customer’s right to self–determination, upon which the Adult Protective Services program is based. No decisions are made about a competent adult without that adult’s involvement and consent. The customer’s consent would be noted in the record. An eligible adult reported to be abused, neglected, financially exploited, or self-neglected, or such adult’s authorized guardian, unless the guardian is the abuser, or the alleged abuser shall have records provided to them upon request. Depending on the nature of the incident of abuse, neglect, or financial exploitation, the customer and /or family members, and providers may be notified. The State has set criteria regarding when notifications are mandatory.

Completed reviews are shared with the OA within 5 days. The OA then provides copies to the applicable ISC agency within 5 days of receipt of the completed review.

The ISC is responsible to ensure the health and welfare of the customer and may recommend additional services and provide monitoring, to protect the customer. Critical incidents may also result in a review of customer needs to determine whether a change in the service or level of service is needed.

The MA and the OA work with Adult Protective Services (APS) and share information in order to improve remediation activities with providers serving customers. The OA and MA staff use the incident information to complete statewide summary and trend analyses to identify, address, and prevent potential abuse, neglect, and exploitation, as well as otherwise seek strategies to enhance the service delivery system.

Beyond allegations of abuse, neglect, and or exploitation addressed above, the OA requires its providers to report directly to the OA other types of critical incidents, including deaths otherwise not reportable to OIG or APS, known injuries, law enforcement involvement, medical emergencies, missing customers, peer-to-peer acts of aggression, unauthorized restraint, injuries of unknown origin, and unscheduled hospitalizations. These reports do not include allegations of abuse, neglect, or exploitation. These incidents are reported electronically to the OA. All reports are accepted. Upon receipt of a report, the ISC agency is automatically notified of the incident. In the case of law enforcement involvement, missing customers, or unscheduled hospitalizations, the ISC agency will work with the reporting provider to take necessary steps to ensure the customer’s safety. All CIRAS submissions require a follow-up entry by the ISC within 10 working days of the initial report. The OA staff use the incident information to complete statewide summary and trend analyses to identify, address, and prevent potential abuse, neglect, and exploitation, as well as otherwise seek strategies to enhance the service delivery system.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The OA oversees the reporting and response of all critical incidents and complaints. The OA uses the Critical Incident Reporting and Analysis System (CIRAS) to analyze trends and to ensure that follow up has occurred. For some individual circumstances, the OA may be working with APS or the ISC to resolve the issue. The State's Adult Protective Services (APS) maintains a tracking system of ANE investigations and statistical reports are generated annually.
Data is used to inform the OA and MA to monitor system performance and remediate problems.

If an Office of Inspector General (OIG) investigation substantiates abuse, neglect or financial exploitation, meaning a preponderance of the evidence supports that the abuse or neglect did occur, the provider is required to submit a Written Response within 30 days for approval by the OA. The Written Response must indicate what actions will be taken to address the issues identified. If a finding of physical abuse, sexual abuse or egregious neglect is substantiated, the perpetrator's name is placed on the Illinois Department of Public Health, Health Care Worker Registry.

The provider is required to inform the victim and the guardian whether the reported allegation was substantiated, unsubstantiated or unfounded. If the provider is unable to reach the customer or guardian by phone, a letter of notification must be sent within 24 hours of receiving notice of the finding.
The OA receives allegations of abuse, neglect and financial exploitation from OIG as reported by complainants to the OIG telephone hotline. These reports are received generally within 2 business days of the allegation being reported. Although OIG investigates, the OA reviews each allegation to determine whether other/additional action is warranted prior to completion of the OIG investigation.

If a finding of physical abuse, sexual abuse or egregious neglect is substantiated following an Adult Protective Services (APS) investigation, the perpetrator's name may be placed on the Adult Protective Services Registry.

The OA receives allegations of abuse, neglect and financial exploitation from APS as reported by complainants to the APS telephone hotline. These reports are received generally within 2 business days of the allegation being reported.

The OA gathers information about the types of allegations and providers to identify patterns and trends.

The OA monitors allegations on an ongoing basis. Summary and analytic reports are developed regarding allegations and findings. These reports are shared with the MA on a quarterly basis during the Quality Management meetings. Summary reports that do not contain confidential information are posted on the OA website.
Both the MA and the OA work together to review performance measures on documentation of the notification to customers of the Rights of the Customer, the reporting of customer deaths, and critical incidents and follow-up methods.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

No form of Restraint shall be permitted except as specified below or as allowed and directed by Administrative Code applicable to the program (e.g. 59 Ill. Adm. Code 119, Developmental Training, 59 Ill. Adm. Code 115, Community Integrated Living Arrangements, 59 Ill. Adm. Code 120, Medicaid Home and Community-Based Services Waiver Program for Individuals with Developmental Disabilities, 405 ILCS 5 Mental Health and Developmental Disabilities Code, etc.) whichever is more restrictive to the use of Restraint.

Restraint shall be used only when the customer's behavior presents an immediate threat of serious physical harm to the customer or others and other less restrictive and intrusive measures have been tried and proven ineffective in stopping the immediate threat of serious physical harm. Restraint shall not be used as discipline or punishment, convenience for staff, retaliation, a substitute for appropriate physical or behavioral support, a routine safety matter, or to prevent property damage in the absence of an immediate threat of serious physical harm to the customer or others. The use of Restraint shall be subject to the following requirements and limitations.

Restraints are only permitted if agreed to by the customer and/or guardian and included in the PCP. Staff who care for customers who have a restraint in their PCP are provided training on the restraint prior to providing care to the customer.

There are restraint training courses available online that teach modern, evidence based de-escalation, crisis prevention, and/or physical intervention techniques for an array of provider types. Courses follow Mandt System of restraint techniques, which utilizes a comprehensive, integrated approach to preventing, de-escalating, and if necessary, intervening when the behavior of an individual poses a threat of harm to themselves and/or others. The Mandt System includes the use of restraint only within the context of a larger restraint reduction methodology. Prevention is the primary strategy for managing aggression, followed by de-escalation tactics. Such courses include but are not limited to Dynamis Training and Insight (https://www.dynamis.training/restraint/), the Crisis Prevention Institute (https://www.crisisprevention.com/), and Certified Restraint and De-escalation Training (https://certifiedrestraint.com/). Each training course has their own techniques for restraining individuals. Most courses also teach non-restraint topics that generally include warning signs of stress, verbal and non-verbal de-escalation, safety when implementing a restraint, and restraint only as a last resort. Types of restraints which are prohibited include prone restraint, supine restraint, mechanical restraint, and chemical restraint other than those medications legally prescribed and administered as part of a customer's regular medical regimen. Allowable restraints are: One Person Supportive Guide; Two Person Supportive Guide; One Person Stability Hold Procedure; Two Person Stability Hold Procedure; and Forward Escort.

A) Restraint may only be employed when:
1. It is included as a modification of rights in a customer's Person-Centered Plan (PCP);
2. The use of Restraint has been discussed and approved for inclusion in the customer's PCP by the customer or guardian, if applicable, and the Provider Support Team;
3. It is included in the customer's behavior plan;
4. The use of Restraint has gone through the Behavioral Management Committee/Human Rights Committee for approval;
5. The inclusion of Restraint in the customer's PCP and behavior plan must include a plan to reduce and ultimately eliminate the use of Restraint, as appropriate;
6. The staff applying the Restraint have been trained in the use of Restraint, as described below, as well as the specific type of the Restraint to be used on the customer;
7. The provider agency has reviewed and determined that there are no known medical or psychological limitations that contraindicate the use of the Restraint;
8. The provider agency has included in the individual rights documentation information for the use of Restraint within the provider agency's policies and procedures and this information has been shared with the customer and guardian, if applicable.

B) Restraint must end immediately when:
1. The immediate threat of serious physical harm ends;
2. The customer indicates that they cannot breathe or staff supervising the customer recognizes they may be in respiratory distress; or

3. The time period of 15 minutes has expired, unless approved in the customer's PCP or a supervisor has approved the instance of the Restraint going beyond 15 minutes.

C) The use of Restraint must be done as follows:
1. Provider agency staff must observe and monitor the customer being physically restrained at all times during the use of Restraint.
2. The staff involved in physically restraining a customer must halt the restraint every 5 minutes to evaluate if the immediate threat of serious physical harm continues to exist. If the immediate threat of serious physical harm continues to exist, staff may continue to use the Restraint and the continued use may not be considered a separate instance of Restraint so long as the total time period of the Restraint does not exceed 15 minutes.
3. A customer shall be released from the Restraint immediately upon a determination by the staff member administering the Restraint that the customer is no longer an immediate threat of causing serious physical harm to themselves or others.
4. The Restraint shall not impair a customer's ability to breathe or communicate normally, obstruct a customer's airway, or interfere with a customer's ability to speak. If the Restraint is imposed upon a customer whose primary mode of communication is sign language or an augmentative mode, the customer shall be permitted to have their hands free of restraint for brief periods, unless the supervising staff determines this freedom appears likely to result in harm to the customer or others.

D) Reporting requirements:
1. In incidents of Restraint, the provider agency shall do the following:
   a. Create a report on the use of Restraint. The Report shall be included in the customer's file and be available for assessment by the Bureau of Quality Management during a provider agency's review.
   b. Review the use of any incident of Restraint via the Human Rights Committee.
2. Any incident of Restraint shall be reported to the provider agency Executive Director/Chief Executive Officer.
3. The provider agency shall notify the customer's guardian, if applicable, no later than 24 hours after any incident of Restraint occurs.

Restraint not identified in the PCP shall be used only when the customer's behavior presents an immediate threat of serious physical harm to the customer or others, the provider agency deems the situation an emergency, and other less restrictive and intrusive interventions have been tried and proven ineffective in stopping the immediate threat of serious physical harm. Restraint not identified in the PCP shall not be used as discipline or punishment, convenience for staff, retaliation, a substitute for appropriate physical or behavioral support, a routine safety matter, or to prevent property damage in the absence of immediate threat of serious physical harm to the customer or others. Restraint not identified in the PCP occurs when the requirements of 1) – 4) above are not in place prior to the use of the restraint. The use of Restraint not identified in the PCP shall be subject to the following requirements and limitations.

A) Restraint not identified in the PCP may only be employed when:
1. The staff applying the Restraint not identified in the PCP have been trained in the use of Restraint;
2. The provider agency has reviewed and determined there are no known medical or psychological limitations that contraindicate the use of the Restraint; and
3. The provider agency has included in the individual rights documentation information on the provider agency's policies and procedures for the use of Restraint and this information has been shared with the customer and guardian, if applicable.

B) Restraint not identified in the PCP must end immediately when:
1. The immediate threat of serious physical harm ends;
2. The customer indicates they cannot breathe or staff supervising the customer recognizes they may be in respiratory distress; or
3. The time period of 15 minutes has expired, unless a supervisor has approved the instance of the Restraint going beyond 15 minutes.

C) The use of Restraint not identified in the PCP must be completed as follows:
1. Provider agency staff must observe and monitor the customer being physically restrained at all times during the use of Restraint.

2. The staff involved in physically restraining a customer must halt the restraint every 5 minutes to evaluate if the immediate threat of serious physical harm continues to exist. If the immediate threat of serious physical harm continues to exist, staff may continue to use the Restraint not identified in the PCP and the continued use may not be considered a separate instance of Restraint not identified in the PCP so long as the total time period of the Restraint not identified in the PCP does not exceed 15 minutes.
3. A customer shall be released from the Restraint not identified in the PCP immediately upon a determination by the staff member administering the Restraint not identified in the PCP that the customer is no longer an immediate threat of causing serious physical harm to themselves or others.
4. The Restraint not identified in the PCP shall not impair a customer's ability to breathe or communicate normally, obstruct a customer's airway, or interfere with a customer's ability to speak. If the Restraint not identified in the PCP is imposed upon a customer whose primary mode of communication is sign language or an augmentative mode, the customer shall be permitted to have their hands free of restraint for brief periods, unless the supervising staff determines this freedom appears likely to result in harm to the customer or others.
5. After Restraint not identified in the PCP has been used, the provider agency shall work with the ISC to determine whether Restraint should be included in the customer's PCP and behavior plan moving forward.

D) Reporting requirements:
1. In incidents of Restraint not identified in the PCP, the provider agency shall do the following:
   a. Create a report on the use of Restraint not identified in the PCP. The Report shall be included in the customer's file and be available for assessment by the Bureau of Quality Management during a provider agency's review.
   b. Review any use of Restraint not identified in the PCP via the Human Rights Committee.
2. Any incident of Restraint not identified in the PCP shall be reported to the provider agency Executive Director/Chief Executive Officer.
3. The Director of the Division of Developmental Disabilities or their designee shall receive a report of each incident of Restraint not identified in the PCP via a report from CIRAS.
4. The provider agency shall notify the customer's guardian, if applicable, no later than 24 hours after any incident of Restraint not identified in the PCP occurs.

CONTINUED TO MAIN B OPTIONAL

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Operating Agency (OA) is responsible for overseeing the permitted use of Restraint and ensuring that State safeguards concerning their use are followed.

The OA contracts with Independent Service Coordination (ISC) agencies to monitor the unauthorized use of Restraint of customers. The ISC conducts a minimum of four visits per year to develop the PCP and monitor the PCP's implementation, including direct, in-person contact with the customer. The ISC's are QIDPs and are subject to mandatory reporting requirements.

ISC's monitor through on-site observations, interviews, and record reviews. Any potential abuse, including the unauthorized use of Restraint would be reported to the OIG or APS (if applicable).

Any findings of unauthorized use of Restraint or of injuries to customers resulting from the use of Restraint regardless of authorization, are required to be reported by the ISC entities to the OA via the OA's Critical Incident Reporting and Analysis System (CIRAS). Findings are documented on the ISC Visiting Notes form, discussed with the provider, and addressed as necessary. Addressing the findings may include reporting potential abuse to the appropriate entity (OIG and/or APS), working with the provider to develop or modify behavior plans and/or any additional action that may be appropriate to the specific circumstances.

If the ISC and provider agency are unable to develop or modify and implement a behavior plan to ensure the unauthorized use of Restraint doesn't happen again, the ISC should refer the matter to the OA using the "Monitoring and Technical Assistance Tool" located here: https://www.dhs.state.il.us/page.aspx?item=56646. The referral must be sent to the OA within two business days. Upon receipt, the referral will be assigned to the appropriate Bureau within the OA for appropriate follow up. The assigned Bureau Chief is responsible for ensuring appropriate and timely follow up. Depending on the nature of the concern being raised by the ISC, the Division may involve additional resources, such as the Support Service Team (SST) and the Bureau of Accreditation, Licensure and Certification (BALC).

Provider agencies are required to report the unauthorized use of Restraint, including any instances not in compliance with State regulations, through CIRAS. If a provider agency is submitting a high number of unauthorized use of Restraint reports through CIRAS, the OA could complete an unannounced review of the provider agency to determine what is causing the high volume of unauthorized Restraint. The OA reviews a statistically valid sample of provider agencies and waiver customers each year to detect the unauthorized use of Restraint, also identifying any service implementation issues such as overuse or inappropriate or ineffective use of Restraint. In completing this review, the OA reviews records; conducts on-site observations; and interviews staff, customers, and guardians.

The OA tracks and analyzes reports received from ISC agencies. The OA maintains a Service Issues Log for this purpose. Summary and analytical data is produced from the log on a quarterly basis and shared and discussed with the MA during the quarterly waiver quality management meetings. In addition to ensuring individual issues are resolved, the OA and MA identify system issues and implement enhancements when necessary. If a trend is identified with a provider agency, the provider agency would be required to submit an approved corrective action plan to the OA. The OA may impose sanctions upon the provider agency up to and including termination of the provider agency.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Providers may use restrictive interventions as a means of last resort and only when necessary to keep individuals safe. When a restrictive intervention is used, there must be safeguards in place to ensure that the restrictive intervention is necessary. The following details the safeguards required to be in place:
1. The Human Rights Committee and Behavior Management Committee must review interventions as indicated by waiver, Rule and DDD policy.
2. An assessment is completed prior to implementation. The assessment must take into consideration a person's medical, emotional, behavioral, environmental and motivational factors.
3. Staff must be appropriately trained on interventions prior to implementing them.
4. Individuals must be informed of the restrictive measure and should be given the option to collaborate as appropriate.
5. Restrictive interventions must be reviewed annually (or more frequently).

Providers may never use restrictive measures that involve the following: a restrictive intervention that is medically contraindicated; a restrictive intervention that is used as punishment; a restrictive intervention that is used for the convenience of providers; or a restrictive intervention that is a substitute for services.

If a medication is being used to change maladaptive behaviors it is a restrictive intervention unless:
1. The medication is used to treat a diagnosed mental illness and the maladaptive behaviors do not warrant a behavior plan.
2. The medications prescribed are FDA approved or commonly used for the treatment of that mental illness diagnosis.
3. Medications used are being prescribed below the maximum dose listed by the Illinois DHS/OCAPs formulary.
4. No more than 3 medications are being prescribed simultaneously for that disorder.
5. No side effects of the medication/s such as sedation are interfering with the individuals adaptive functioning.
6. The person has not required any other restrictive interventions in the previous 6 months.

A restrictive intervention may be instituted immediately if the individual's immediate safety is in jeopardy. If a restrictive intervention is instituted immediately, the safeguards itemized above must be completed within a week of the restrictive intervention.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The Operating Agency (OA) is responsible for overseeing the permitted use of Restrictive Intervention and ensuring that State safeguards concerning their use are followed.

The OA contracts with Independent Service Coordination (ISC) agencies to monitor the unauthorized use of Restrictive Intervention of customers. The ISC conducts a minimum of four visits per year to develop the PCP and monitor the PCP's implementation, including direct, in-person contact with the customer. The ISC's are QIDPs and are subject to mandatory reporting requirements.

ISC's monitor through on-site observations, interviews, and record reviews. Any potential abuse would be reported to the OIG or APS as applicable.

Any findings of unauthorized use of Restrictive Intervention or of injuries to customers resulting from the use of Restrictive Intervention regardless of authorization, are required to be reported by the ISC entities to the OA via the OA's Critical Incident Reporting and Analysis System (CIRAS). Findings are documented on the ISC Visiting Notes form, discussed with the provider, and addressed as necessary. Addressing the findings may include reporting potential abuse to the appropriate entity (OIG and/or APS), working with the provider to develop or modify behavior plans and/or any additional action that may be appropriate to the specific circumstances.

If the ISC and provider agency are unable to develop or modify and implement a behavior plan to ensure the unauthorized use of Restrictive Intervention doesn't happen again, the ISC should refer the matter to the OA using the "Monitoring and Technical Assistance Tool" located here: https://www.dhs.state.il.us/page.aspx?item=56646. The referral must be sent to the OA within two business days. Upon receipt, the referral will be assigned to the appropriate Bureau within the OA for appropriate follow up. The assigned Bureau Chief is responsible for ensuring appropriate and timely follow up. Depending on the nature of the concern being raised by the ISC, the Division may involve additional resources, such as the Support Service Team (SST) and the Bureau of Accreditation, Licensure and Certification (BALC).

Provider agencies are required to report the unauthorized use of Restrictive Intervention, including any instances not in compliance with State regulations, through CIRAS. If a provider agency is submitting a high number of unauthorized use of Restrictive Intervention reports through CIRAS, the OA could complete an unannounced review of the provider agency to determine what is causing the high volume of unauthorized Restrictive Intervention. The OA reviews a statistically valid sample of provider agencies and waiver customers each year to detect the unauthorized use of Restrictive Intervention, also identifying any service implementation issues such as overuse or inappropriate or ineffective use of Restrictive Intervention. In completing this review, the OA reviews records; conducts on-site observations; and interviews staff, customers, and guardians.

The OA tracks and analyzes reports received from ISC agencies. The OA maintains a Service Issues Log for this purpose. Summary and analytical data is produced from the log on a quarterly basis and shared and discussed with the MA during the quarterly waiver quality management meetings. In addition to ensuring individual issues are resolved, the OA and MA identify system issues and implement enhancements when necessary. If a trend is identified with a provider agency, the provider agency would be required to submit an approved corrective action plan to the OA. The OA may impose sanctions upon the provider agency up to and including termination of the provider agency.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The Operating Agency (OA) is responsible for detecting the unauthorized use of seclusion.

The OA contracts with Independent Service Coordination (ISC) agencies to monitor the unauthorized use of Seclusion of customers. The ISC conducts a minimum of four visits per year to develop the PCP and monitor the PCP's implementation, including direct, in-person contact with the customer. The ISC's are QIDPs and are subject to mandatory reporting requirements.

ISC's monitor through on-site observations, interviews, and record reviews. Any potential abuse, including the unauthorized use of Seclusion would be reported to the OIG or APS (if applicable).

Any findings of unauthorized use of Seclusion or of injuries to customers resulting from the use of Seclusion are required to be reported by the ISC entities to the OA via the OA's Critical Incident Reporting and Analysis System (CIRAS). Findings are documented on the ISC Visiting Notes form, discussed with the provider, and addressed as necessary. Addressing the findings may include reporting potential abuse to the appropriate entity (OIG and/or APS), working with the provider to develop or modify behavior plans and/or any additional action that may be appropriate to the specific circumstances.
If the ISC and provider agency are unable to develop or modify and implement a behavior plan to ensure the unauthorized use of seclusion doesn't happen again, the ISC should refer the matter to the OA using the "Monitoring and Technical Assistance Tool" located here: https://www.dhs.state.il.us/page.aspx?item=56646. The referral must be sent to the OA within two business days. Upon receipt, the referral will be assigned to the appropriate Bureau within the OA for appropriate follow up. The assigned Bureau Chief is responsible for ensuring appropriate and timely follow up. Depending on the nature of the concern being raised by the ISC, the Division may involve additional resources, such as the Support Service Team (SST) and, the Bureau of Accreditation, Licensure and Certification (BALC).

Provider agencies are required to report the unauthorized use of Seclusion, including any instances not in compliance with State regulations, through CIRAS. If a provider agency is submitting a high number of unauthorized use of Seclusion reports through CIRAS, the OA could complete an unannounced review of the provider agency to determine what is causing the high volume of unauthorized Seclusion. The OA reviews a statistically valid sample of provider agencies and waiver customers each year to detect the unauthorized use of Seclusion, also identifying any service implementation issues such as overuse or inappropriate use of Seclusion. In completing this review, the OA reviews records; conducts on-site observations; and interviews staff, customers, and guardians.

The OA tracks and analyzes reports received from ISC agencies. The OA maintains a Service Issues Log for this purpose. Summary and analytical data is produced from the log on a quarterly basis and shared and discussed with the MA during the quarterly waiver quality management meetings. In addition to ensuring individual issues are resolved, the OA and MA identify system issues and implement enhancements when necessary. If a trend is identified with a provider agency, the provider agency would be required to submit an approved corrective action plan to the OA. The OA may impose sanctions upon the provider agency up to and including termination of the provider agency. The OA collects data on the reporting of critical incidents, restraint, restrictive interventions, and seclusion as outlined in Appendix G - Performance Measures. The data is summarized and presented at the quarterly Waiver Quality Management meetings. The MA and the OA review summary data, remediation activities and identify trends over time as well as the effectiveness of policies and procedures.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

A physician shall be responsible for the medical services provided to customers and the management of customers' medications.

59 Ill. Adm. Code 116 requires that residential habilitation providers must have a registered professional nurse, advanced practice nurse, physician licensed to practice medicine in all its branches, or a physician assistant on duty or on call at all times. At least quarterly, this professional reviews medication orders, medication labels and Medication Administration Records (MAR) to ensure that medication labels and medications administered match those ordered. The professional completing the review should report any identified discrepancy to necessary parties which could include the pharmacy, medical professional, QIDP or provider administrator as necessary and ensure the discrepancy is corrected.

Licensing rule 59 Ill. Adm. Code 115 requires that customers in a residential setting who are receiving prescription medications must be seen by the prescribing physician minimally every six months to review the medication use, and minimally every three months if the customer is receiving psychotropic medications. A psychiatrist will either review psychotropic medications or be available for consultation when psychotropic medications have been prescribed for a customer.

A physician or pharmacist shall make available to employees, family and customers information on expected consequences, potential benefits and side effects of any prescribed medication.

For customers receiving psychotropic medications, a screening for and documentation of abnormal involuntary movements, including tardive dyskinesia, is completed at least every six months by a licensed health care professional or a person trained in performing this type of assessment. The assessment is maintained in the customer’s file with the residential provider. If there is an abnormal screening based on the assessment, the prescribing professional must be notified.

Use of psychotropic medications to modify or control behaviors or treatment of mental illness is considered a restrictive intervention. As such, it is also subject to the provider requirements for oversight by a properly constituted human rights committee as described in G-2.

During its licensure surveys, the Bureau of Accreditation, Licensure, and Certification (BALC) reviews whether the required supervision and assessments by licensed professionals described above occur within the time frames required by rule. In addition, registered professional nurses employed by the OA conduct on-site visits to ensure compliance with 59 Ill. Adm. Code 116 regarding the review of all medications, including behavior modifying medications. These reviews include, but are not limited to, physician oversight, nursing supervision, administration, record-keeping, storage, disposal, errors, and harmful or unsafe practices. The protocol used by the licensure teams and the protocol used by the nurses are available upon request from the OA.

Community Day Service (CDS) providers, including Developmental Training providers, are permitted to allow non-licensed direct support persons to administer medications in accordance with Administrative Rule 116.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

(a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications);

Residential providers subject to medication administration requirements are monitored by the OA for compliance. OA staff monitoring for compliance are all registered nurses. Providers are required to track all medication errors and to report to the OA all errors with an adverse outcome (defined as requiring medical attention) by fax to the OA's Bureau of Quality Management (BQM). The error reports are forwarded to the OA's nurse reviewers for review and follow up with the provider.

Per Title 59 Illinois Administrative Code Part 116, a medication error shall be immediately reported to the registered professional nurse, advanced practice nurse, physician, physician assistant, dentist, podiatrist or certified optometrist to receive direction on actions to be taken. All medication errors shall be documented in the customer's clinical record and a medication error report shall be completed within eight hours or before the end of the shift in which the error was discovered, whichever is earlier. A copy of the medication error report shall be maintained as part of the agency's quality assurance program.

(b) the method(s) for following up on potentially harmful practices;

Any medication error that results in an adverse outcome is reported to the OA within seven calendar days. All reports are reviewed by the OA, coordinated with an OIG investigation, and followed up as necessary to ensure that adequate safeguards are in place to prevent future occurrences. Based on the outcome of an OIG investigation, the OIG makes recommendations to the provider and requires a corrective action plan. In instances where potentially harmful practices are identified, the OA provides technical assistance to the provider.

(c) the state agency (or agencies) that is responsible for follow-up and oversight.

In addition, the OA annually conducts on-site reviews of a representative sample of customers. The OA review team includes Registered Nurses on each review. The team reviews customer medication regimen, medication administration, and compliance with rules applicable to medication management and administration.

The OA monitors for the following: written policies and procedures on reviewing adverse drug reactions; written policies and procedures on the review of medication errors; whether a medication error report is made for every medication error noted on the MAR; whether a review of medication administration is conducted by the nurse-trainer on a quarterly basis and that medication labels and MARs match the physician order sheets; and whether medications are being administered as prescribed and whether refusals are documented properly; and whether medication errors are reviewed by the nurse-trainer within 7 days of each occurrence.

When findings are discovered, the provider is required to develop a corrective action plan subject to the approval of the OA. The remediation must address the customer's finding(s) as well as any other similar practices involving other customers served by the provider. The provider must develop a quality assurance process to prevent future occurrences.

If serious findings are discovered, an immediate corrective action can be required (meaning remediation must occur before the OA reviewer exits the provider) or within a short time frame no more than 48 hours of the completion of the review. Plans to safeguard the welfare of customers until corrective action is implemented can include increased monitoring visits or moving waiver customers either temporarily or permanently to other settings.
OA findings are summarized and reported at the Waiver Quality Management meetings which includes key staff from the OA and MA. The Waiver Quality Management team meets quarterly and develops appropriate system improvements in response to identified trends and concerns. The meeting summary is a record of system improvements and outcomes.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

When medications are provided or employees of a waiver Residential Habilitation provider supervise their administration, the provider must ensure that such medications are provided and their administration is supervised in accordance with the Illinois Nursing and Advanced Practice Nursing Act (225 ILCS 65). Residential Habilitation service providers may allow non-licensed direct support persons to administer medications if the provider complies with the Administration of Medication in Community Settings rule (59 Ill. Adm. Code 116).

When providers supervise the self-administration of medication training programs or administer the medications, medications must be secured from unauthorized access and only a physician, pharmacist, registered or licensed practical nurse or agency employee authorized to supervise the self-administration of medication training program or administer medications may have access to medications. A physician, pharmacist or registered professional nurse must be available at all times to consult with trained, unlicensed direct support employees administering medications or supervising a self-administration of medications training program for customers with developmental disabilities.

A medical professional must evaluate the ability of the customer to self-administer medications. Ability to self-administer medication must be reassessed at least annually. Customers must be evaluated using OA approved screening and assessment tools, in accordance with 59 Ill. Adm. Code 116.
A prescribing medical professional must provide the written order for a waiver customer to self-administer medications or participate in a self-administration of medication training program based on the results of the customer's evaluation. The order must become part of the customer's record.
The provider must ensure and document the following:

-A prescribing medical professional must be responsible for the medical services provided to customers, and the management of a customer's medications.
-Only a medical professional, that is, a physician licensed pursuant to the Medical Practice Act, advanced practice nurse licensed pursuant to the Nursing and Advanced Practice Nursing Act, and physician's assistant licensed pursuant to Physician Assistant's Practice Act, may prescribe and monitor all prescription medications.

-All medications, including patent or proprietary medications, e.g., cathartics, headache remedies, or vitamins, may be given only upon the written order of a competent medical professional. Rubber stamp signatures are not acceptable. All orders must be given as prescribed by the medical professional and at the designated time. A registered professional nurse or licensed practical nurse may take telephone orders. All orders must be immediately signed by the nurse taking the order and placed in the customer's record. These orders must be countersigned or documented by facsimile prescription by the medical professional within ten working days.

OA Administrative Rule 116 permits a registered nurse who has successfully completed the OA/IDHS-approved nurse-trainer course for medication administration in the community (5 hours) to authorize direct support personnel to administer medication in residential sites. Authorized direct support personnel must be at least eighteen, have completed high school or G.E.D., demonstrate functional literacy, and have successfully completed 8 hours of classroom training on medication administration. In addition, competency-based training is required specific to the customer, the medication, and the dosages. Direct support personnel are authorized to administer only those specific medications to specific customers for which they have successfully completed training and competency evaluations. Authorized direct support personnel are re-evaluated by a nurse-trainer at least annually to ensure competency to administer each medication to each customer.

The MAR for the current month must be kept with the medications or in the customer's record. The MAR must be completed and initialed immediately after the medication is administered. Each MAR must have a section that contains the full signature and title of each person who initials it. All changes in medication must be noted on the MAR by a nurse, physician, physician assistant, dentist, podiatrist, or certified optometrist and shared with administering staff prior to the next dose. Upon the direct instruction of a Nurse-Trainer, authorized direct care staff may indicate on the MAR completion of the following actions: discontinuation of a medication, change in medication schedule, and/or application of a medication information label issued with a medication by a licensed pharmacy. Customer refusal to take a medication must be noted on the MAR and in the customer's record indicating the reason for the refusal The RN Trainer should be notified of the medication refusal.

An individual Medication Administration Record (MAR) must be kept for each customer for medication administered. It must contain at least the following:

1) the customer's name;
2) the name and dosage form of the drug;
3) the name of the prescribing physician, physician assistant advanced practice nurse, dentist, podiatrist, or certified optometrist;
4) dose;
5) frequency or times of administration;
6) route of administration;
7) date and time given;
8) customer's allergies to medication; and
9) any special considerations.

For waiver customers who are independently self-administering medications, no MAR is required; however, the provider must track and document that the medications are being taken by the customer.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Medication errors are defined in 59 Ill. Adm. Code 116 as: The administration of medication other than as prescribed, resulting in the wrong medication being given; or medication being given at the wrong time, in the wrong dosage, via the wrong route, or by the wrong person; or medication omitted entirely. It is meant to include a lack of documentation of medication administration or any error in that documentation. Medication errors must be documented and are subject to review by the OA. Medication errors that meet the reporting criteria in IDHS' rules on Office of Inspector General Investigations of Alleged Abuse or Neglect or Deaths in State-Operated and Community Agency Facilities (59 Ill. Adm. Code 50) shall be reported to the Office of Inspector General. Medication errors which result in an adverse outcome (defined as requiring medical attention) are reported by fax to the OA's Bureau of Quality Management (BQM). The error reports are forwarded to the OA's nurse reviewers for review and follow up with the provider.

(b) Specify the types of medication errors that providers are required to *record:*

Waiver Residential Habilitation providers are required to record all medication errors.

Medication errors are defined in 59 Ill. Adm. Code 116 as: The administration of medication other than as prescribed, resulting in the wrong medication being given; or medication being given at the wrong time, in the wrong dosage, via the wrong route, or by the wrong person; medication omitted entirely; or the customer refuses the medication. It is meant to include a lack of documentation of medication administration or any error in that documentation.

(c) Specify the types of medication errors that providers must *report* to the state:

Residential providers subject to medication administration requirements are monitored by the OA for compliance. Providers are required to track all medication errors and to report to the OA all errors with an adverse outcome (defined as requiring medical attention) by fax to the OA's Bureau of Quality Management (BQM). The error reports are forwarded to the OA's nurse reviewers for review and follow up with the provider.

Any medication error that results in an adverse outcome is reported to the OA within seven calendar days. All reports are reviewed by the OA, coordinated with an OIG investigation, and followed up as necessary to ensure that adequate safeguards are in place to prevent future occurrences.
Also, any medication errors that are reported through the critical incident reporting process are also reviewed by the OA and the MA at the quarterly waiver compliance management meetings.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Residential providers subject to medication administration requirements are monitored by the OA for compliance. Providers are required to track all medication errors and to report to the OA all errors with an adverse outcome (defined as requiring medical attention) through the Critical Incident Reporting and Auditing System (CIRAS). Any medication error that results in an adverse outcome is reported to the OA within seven calendar days. All reports are reviewed by the OA, coordinated with an OIG investigation, and followed up as necessary to ensure that adequate safeguards are in place to prevent future occurrences.

The OA reviews a representative sample of waiver customers annually. The OA review team includes Registered Nurses on each review. The team reviews customer medication regimen, medication administration, all medication errors, and compliance with rules applicable to medication management and administration.

The OA monitors for the following: written policies and procedures on reviewing adverse drug reactions; written policies and procedures on the review of medication errors; whether a medication error report is made for every medication error noted on the MAR; whether a review of medication administration is conducted by the nurse-trainer on a quarterly basis and that labels match the physician order sheets; and whether medications are being administered as prescribed and whether refusals are documented properly; and whether medication errors are reviewed by the nurse-trainer with 7 days of each occurrence.

A medication error shall be immediately reported to the registered professional nurse, advanced practice nurse, physician, physician assistant, dentist, podiatrist, or certified optometrist to receive direction on actions to be taken. All medication errors shall be documented in the customer’s clinical record and a medication error report shall be completed within eight hours or before the end of the shift in which the error was discovered, whichever is earlier. A copy of the medication error report shall be maintained as part of the agency's quality assurance program.

In addition to the review of all medication errors through its representative sample of waiver customers, as well as its review of providers’ written policies and procedures on the review of medication errors, any medication error that results in an adverse outcome is reported to the OA within seven calendar days. All reports are reviewed by the OA and followed up as necessary to ensure that adequate safeguards are in place to prevent future occurrences.

When findings are discovered, the provider is required to develop a corrective action plan subject to the approval of the OA. The remediation must address the customer’s finding(s) as well as any other similar practices involving other customers served by the provider. The provider must develop a quality assurance process to prevent future occurrences.

If serious findings are discovered, an immediate corrective action can be required (meaning remediation must occur before the OA reviewer exits the provider) or within a short time frame no more than 48 hours of the completion of the review. Plans to safeguard the welfare of customers until a corrective action is implemented can include increased monitoring visits or moving waiver customers either temporarily or permanently to other settings.
OA findings are summarized and reported at the Waiver Quality Management meetings which includes key staff from the OA and MA. The Waiver Quality Management team meets quarterly and develops appropriate system improvements in response to identified trends and concerns. The meeting summary is a record of system improvements and outcomes.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G1 Number and percent of records reviewed where the customer/guardian received info about how and to whom to report unexplained deaths and A/N/E at the time of each assessment. N: Number of records reviewed where the customer/guardian received info about how and to whom to report unexplained deaths and A/N/E at the time of each assessment. D: Total number of records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G2 # and % of unexplained deaths and substantiated incidents of A/N/E reported to the OA where appropriate actions were taken to address incident. N: # of unexplained deaths and substantiated incidents of A/N/E reported to the OA where appropriate actions were taken to address incident. D: # of unexplained deaths and substantiated incidents of A/N/E reported to the OA.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(check each that applies):*	
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G3 # and % of customer deaths related to substantiated cases of abuse or neglect reported to the OA where actions were taken to address incident. N: # of customer deaths related to a substantiated case of abuse or neglect reported to the OA where actions were taken to address incident. D: Total # of customer deaths related to a substantiated case of abuse or neglect reported to the OA.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G4 Number and percent of critical incident trends where systemic intervention was

implemented. N: Number of critical incident trends where systemic intervention was implemented. D: Total number of critical incident trends.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G5 # and % of substantiated incidents of restrictive intervention, including restraint, reported to the OA where appropriate actions were taken to address the incident. N: # of substantiated incidents of restrictive intervention, including restraint, reported to the OA where appropriate actions were taken to address the incident. D: Total # of substantiated incidents of restrictive intervention.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports; Substantiated Incidents

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**

☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
G6 Number and percent of direct support staff who received training on alternative practices to restrictive interventions, including restraints and seclusion. N: Number of direct support staff who received training on alternative practices to restrictive interventions, including restraints and seclusion. D: Total number of direct support staff.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Direct Support Staff Training Report

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G7 Number and percent of customer survey respondents who reported being treated well by direct support staff. N: Number of customer survey respondents who reported being treated well by direct support staff. D: Total number of customer survey respondents.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Satisfaction surveys

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G8 Number and percent of customers reporting that they visited a doctor or practitioner for an annual screening within the last 12 months. N: Number of customers reporting that they visited a doctor or practitioner for an annual screening within the last 12 months. D: Total number of customer records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% confidence level with a +/- 5% margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

G1: The OA will assure that customers know how to report abuse, neglect, or exploitation. This will be demonstrated by correction of case work documentation reflecting customers awareness, including evidence of steps taken to educate the customer. Remediation must be completed within 30 days.

G2: The OA will follow up all outstanding referrals of substantiated incidents. Changes in customer's PCP, corrective action plans or provider sanctions will be made when needed. Remediation must be completed within 30 days.

G3: The cause of death/circumstances would be reviewed by the OA and need for training or other remediation; including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns. Resolution or remediation timeframe would be case-specific.

G4: The OA will review all outstanding critical incidents with the MA to identify trends and implement systemic interventions, that may include training, a plan of correction, or other remediation to assure that critical incidents are being analyzed to determine root cause. Remediation must be completed within 30 days.

G5: The OA will follow up all outstanding APS referrals of substantiated incidents of confinement. Changes in customer's PCP, corrective action plans or provider sanctions will be made when needed. Remediation must be completed within 30 days.

G6: The OA will follow up to ensure that training has been provided on alternative practices to restrictive interventions, including restraints and seclusion, within 30 days of notification. Training sign-in sheets will be reviewed to ensure all staff completed the training.

G7: If identifying information is available for individual surveys, the ISC staff will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Patterns of negative responses, including anonymous survey responses, will be used to identify need for system improvement.

G8: During the initial evaluation or redetermination, the ISC staff will ask whether the customer has a primary care doctor or practitioner and whether they had a physical in the last 12 months. If not, barriers will be identified and addressed. Remediation will occur at the meeting between customer and ISC staff.

The OA is responsible for seeing that these individual findings are resolved. The OA provides quarterly reports of these activities to the MA. Staff of the two State agencies review the reports on a quarterly basis.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Illinois Department of Healthcare and Family Services, as the single State Medicaid Agency (MA), and the Illinois Department of Human Services, Division of Developmental Disabilities, as the Operating Agency (OA) work in partnership to evaluate the waiver Quality Management System (QMS). This partnership provides analysis to information derived from discovery and collaboratively develops and monitors remediation activities for each of the federal assurances.

The OA and MA share reports that track changes in compliance levels for performance measures over time. This includes tracking changes across the entire state. This helps to identify problematic areas and potential best practices. Together, the MA and OA aggregate information and generate reports on a quarterly basis.

The OA currently receives and maintains data from the Abuse/Neglect/Exploitation database and the Complaint database, and the Critical Incident Reporting and Analysis System (CIRAS) database. Summary information and trend analysis is discussed during quarterly Waiver Quality Management Committee meetings of the MA and OA staff. Necessary remediation is identified and documented on the System Improvement Log maintained by the MA.

The OA is responsible for the majority of the data collection to address the Quality Management System discovery and remediation activities. The OA is primarily responsible for eligibility and authorizing qualified providers. Therefore, there are distinct performance measures for these functions under the OA. Additionally, as a result of enhancements in the MA’s data systems, the MA now includes qualified provider performance measures. The MA is specifically accountable for the measures in Appendix C Qualified Providers. The state's system improvement activities are in response to aggregated and analyzed discovery and remediation data collected on each of the waiver performance measures.

The sources of discovery evidence vary, but all are based on either a 100% review or the representative sampling methodology as indicated for each performance measure. The OA annually selects a representative sample of waiver customers. Onsite, desk audit, remote or virtual, as appropriate, reviews are scheduled and conducted throughout the year at Independent Service Coordination agencies and waiver service providers. Data is collected throughout the year and individual problems are remediated as they are identified. Other data sources include the State Medicaid Management Information System (MMIS) and other reports as indicated in the waiver.

The OA takes a multi-phased and multilevel approach to using reports to improve the overall system. Because changes in the compliance level for a performance measure may be explained by an external factor that would not require remediation (e.g., better targeting of customers with greater impairment than may have an adverse impact on some of the performance measures), the first step is to investigate to try to determine if an actual problem exists. The second step is to formulate potential interventions that may remediate the problem. The third step is to roll out those interventions, possibly on a pilot basis. The final step is to track changes using the original performance measures to assess the impact of intervention.

The state's quality oversight system between the MA and the OA is hierarchical. With regards to waiver management, the process described above is multilevel. The MA oversees the OA, which oversees the ISC agencies, which employs the independent service coordinators. Consequently, the state's quality management system includes regular and structured oversight meetings to facilitate communication, investigation, and problem solving across the many levels. The OA meets with all ISC agencies at least quarterly and meets with a representative sample of independent service coordinators at least annually, and more often if required due to performance issues. The OA and MA meet quarterly.

The Adults with Developmental Disabilities waiver Quality Improvement Plan (QIP) is part of an overall quality management plan for the three 1915 (c) waivers operated by the IDHS, Division of Developmental Disabilities (OA). The other waivers include the Children's Support Waiver (0464), and the Children’s Residential Waiver (0473). While some data may be collected during the same on-site provider reviews, the sample for each waiver is drawn separately and the results aggregated separately.

On a quarterly basis, the MA conducts Quality Management Committee (QMC) meetings with the OA to review data collected from the previous quarter and for the year to date. Data is collected on a regular basis and is reported as indicated by the performance measure in the waiver. All reports will be provided to the MA for review prior to the quarterly meetings. Annual reports are produced identifying trends based on the representative sample

and/or 100% review of data.

The OA reports on all data collected for the three developmental disabilities waivers, however data is reported separately, by waiver. Data is reported by individual performance measure and in total for comparison to all performance measures. Individual performance measure reports include timeliness of remediation based on immediate, 30, 60, 90-day increments and remediations outstanding.

During quarterly meetings, the MA and the OA identify trends based on scope, severity, changes and patterns of compliance by reviewing both the levels of compliance with the performance measures and remediation activities conducted by the OA. Identified trends are discussed and analyzed regarding cause, contributing factors and opportunities for system improvement. Systems improvement is prioritized based on the overall impact to the customers and the program. System improvements may be prioritized based on factors such as: the impact on the health and welfare of waiver customers, legislative considerations, and fiscal considerations. Decisions and timelines for system improvement are based on consensus of priority and specific steps needed to accomplish change. These decisions are documented and communicated through the sharing of the quarterly meeting summary.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

For the OA, the state uses the same mechanisms that it uses to identify potential issues including contract compliance, customer satisfaction, assurances, and critical incident analysis to monitor the effectiveness of all interventions. The state tracks changes in the performance measures using data analysis and reports.

For the OA, customer input also plays a central role in the QIP as follows: Customers' perception of the quality of their services using constructs that are meaningful to customers (e.g., integration in the community, dignity, respect, etc.) as gathered through customer satisfaction tools and the assessment tool. These tools provide the OA with the direct feedback loop about the effect of potential interventions on the quality of life for individual customers.

The processes Illinois follows to continuously evaluate the effectiveness of the QIP are the same processes to evaluate the information derived from discovery and remediation activities. The Waiver Quality Management Committee (QMC) uses documentation that is discussed quarterly by key staff of the MA and the OA regarding progress, updates, and evaluation of effectiveness. Effectiveness is measured by impact on performance based on ongoing data collection over time, feedback from customer/guardian interviews, surveys, and service providers. Multiple years of data collection will allow the State to evaluate the effectiveness of system improvements over time. One meeting of the Waiver QMC each year is partly devoted to an overview of the previous year's activities and a discussion of whether changes are needed to the QIP. System design changes may be specific to the OA or one waiver or may involve multiple waivers. The purpose of meeting annually is to provide an arena to see the system holistically, determine how well the system design changes are working, and identify areas that require further improvement.

In the OA QIP, the State has implemented additional efforts to address its ability to improve and maintain quality. These include:
1) Updated performance measures in each of the waiver areas,
2) Redesigned reports to be used on a quarterly basis,
3) Updated CIRAS Manual updating and clarifying reporting processes, enrollment processes, reporting requirements, definitions of critical incidents Event Report system and clearer delineation of critical incident definitions and follow-up procedures including training for ISCs and service providers on reporting and management of critical events,
4) Implementation of new process and tracking system for implementation deadlines for substantiated OIG findings,
5) Implementation of additional review questions to evaluate customer satisfaction.

The OA meets with the Developmental Disabilities Advisory Committee (DDAC) multiple times a year to present information about the waiver and receive input from providers, stakeholders, and customer representatives. The DDAC has several temporary work groups to address identified topics, including a technology work group and home-based services work group. This process of inclusion of stakeholders has been most effective and is viewed by the OA as a critical element in its QIP. Meeting dates and times are shared with the MA for their information and participation.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

During the quarterly meetings with the OA, the OA and MA review Performance Measure reporting and the QIP. The OA and the MA discuss updates that both Departments need to address in the future. The OA also seeks input from its DDAC and advocacy groups on improvements and/or changes to the QIP. The OA continually addresses issues as they arise, responds, and implements strategies to improve compliance with performance indicators. The whole QIP is viewed as a continuous ongoing process.

One wavier QMC meeting a year is dedicated to discussing statewide issues impacting the waiver. During this annual meeting, the OA has on the agenda an overview of the previous year's activities and a discussion of whether changes are needed to the QIP. The MA and the OA see five primary focus areas: These areas are described below.
1) Structure of the QMC: The group reviews the structure of the QMC to determine if it is effective.
2) Trend Analysis: The group evaluates the processes for identifying trends, patterns, and root causes to assure that issues are being identified and analyzed.
3) Systems Improvement: The group reviews the QIP documentation to assure that all recommendations have been implemented in accordance with agreed upon timelines, and if not, whether there is justification.
4) System Improvement Priorities: The methods for determining system improvement priorities are evaluated to determine effectiveness.
5) Performance Measures: The entities determine whether to make changes in existing performance measures, add measures, or discontinue measures.

Other elements of performance measures are reviewed for effectiveness, including: the frequency of data collection, source of data, sampling methodology, and remediation.

The state continuously strives to increase the compliance rate of each performance measure. While the target compliance rate for each performance measure is 100%, the state realizes that it may take multiple system changes over several years to reach the goal of 100% compliance, as well as, all entities involve experience staff changes that require ongoing training.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the*

financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) requirements concerning the independent audit of provider agencies

Audit requirements differ depending on the amount paid to the provider by the OA. Providers that receive from $500,000.00 to $749,999.99 from the OA must submit a financial statement audit conducted in accordance with Generally Accepted Auditing Standards (GAAS). Providers that receive $750,000.00 or more through the OA, must submit a financial statement audit conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS). Staff in the Office of Contract Administration (OCA) review the audits and ensure each agency required to complete an audit have done so. Failure to comply with reporting requirements shall result in the withholding of funds, the return of improper payments or Unallowable Costs, will be considered a material breach of this Agreement and may be the basis to recover Grant Funds. Grantee's failure to comply with Articles XIII, XIV, or XV of the Uniform Grant Agreements (UGA) shall be considered prima facie evidence of a breach and may be admitted as such, without further proof, into evidence in an administrative proceeding before Grantor, or in any other legal proceeding. Grantee should refer to the State of Illinois Grantee Compliance Enforcement System for policy and consequences for failure to comply. If the OA performs rate calculations or expense and revenue analysis, provider agencies are required to submit revenue and expense data by program in a consolidated financial report form prescribed by the OA, regardless of overall funding level. Individual providers and businesses that are not under contract with the OA are not required to obtain and submit audits on their financial information. However, the OA reserves the right to audit any provider at any time.

(b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits;

The Office of Contract Administration (OCA) performs desk reviews for 100% of the required provider audits on an annual basis. The types of findings and discrepancies reported by provider's independent auditors may include segregation of duties, issues with internal controls, inability to accurately prepare financial statements, misappropriation of funds, eligibility of services, accurate reporting of billings, and inappropriate costs. Once OCA completes their review of the independent provider audits, OCA submits a Desk Review Letter to the provider which closes the review, requests additional information, or identifies findings and requires a Corrective Action Plan (CAP). If a CAP is required, the provider has 30 days to submit the CAP to OCA with timelines identified to meet compliance. The provider will submit proof of compliance within the timelines or OCA will follow up with the provider until compliance is met. Copies of the independent provider audits and consolidated financial reports (CFR's) are on file with the OCA and are available to the OA upon request. These annual audits are conducted in accordance Generally Accepted Auditing Standards (GAAS) or Government Auditing Standards (GAGAS) depending on the level of funding that a provider receives.

30 ILCS 5/3 specifies the jurisdiction of the Auditor General and section 3-2 identifies the mandatory post audits. The Auditor General shall conduct a financial audit, a compliance audit, or other attestation engagement, as is appropriate to the agency's operations under generally accepted government auditing standards. In conjunction with HFS' portion of the Statewide Single Audit, a sample of provider billings for Medicaid payments that may include billings for Medicaid payments for waiver services is reviewed. The Illinois Office of Auditor General is responsible for conducting the financial audit program.

The MA and OA work cooperatively to review rates and provider claims. The MA implements procedures that provide assurances that claims will be coded and paid in accordance with the reimbursement methodology specified in the waiver. The MA delegates to the OA the financial oversight of claims.

The OA's computer system generates applicable rates and service authorizations according to the waiver program parameters for which the customer is authorized to participate. Each customer's service authorization(s) of which some are provider agency specific where only the specified provider can bill and receive payment and others are generic where any qualified and enrolled provider can bill and be paid are transmitted from the OA's computer system to the OA's Community Reimbursement Sub-system (CRS). The OA's computer system can either produce individualized or statewide rates as set by the OA's rate setting methodologies. The OA's computer system also transmits the individualized or statewide rates to the OA's (CRS) which maintains a complete historical record of every customer's authorization(s) for services and rates.

CRS also contains each provider's eligibility to provide services and what services the provider is eligible to provide, bill and be paid for. Each provider or provider agency submits billing through the OA's Reporting of Community Services (ROCS) system. ROCS reporting from each provider or provider agency includes the customer's information of the first, last and middle initial of the customer's name, Social Security Number (SSN), Recipient Identification Number (RIN) if one has been assigned, and Date of Birth (DOB). The provider or provider agency also reports specific bill codes for each service delivered, quantity of services delivered and bill rate. All ROCS billing is transmitted to the CRS. The CRS batch processes all ROCS billing on a weekly basis. The CRS has edits which check for the customer's identity against the

customer's information in CRS. The customer's Medicaid eligibility on the day services were delivered and being billed for, the customer is authorized for the service being billed and the service was authorized for the date service(s) are being billed. The CRS also compares the provider's billing rate against either the statewide billing rate or the customer's authorized individualized rate for the applicable service and bill code.

The CRS adjudicates all provider billing based on the customer's eligibility for services on the date services were delivered by the provider or provider agency. The CRS performs edit checks that the provider or provider agency is eligible to deliver the service being billed. CRS also adjudicates the payment for services based on the OA's authorized rate for the customer for each service. CRS rejects and does not pay for any services which do not pass all of the above listed edits including services provided before or after a customer's service authorization for each service.
Other edits ensure appropriate billing is submitted by the provider or provider agency include that the CRS reject billing for services prior to the customer's determined date of eligibility for DD services by the ISC.

Another safeguard for all provider billings is that CRS will reject any billing if the billing was previously submitted, adjudicated and paid. Provider agencies cannot bill over the authorized number of units for a day or month of service nor can a provider or provider agency bill over the annually authorized number of units of any specific service for the customer.

The OA reviews 100% of claims verifying the following:
1. The customer was eligible and enrolled in the waiver on the date of service, and,
2. The rates were paid in accordance with the reimbursement methodology.

In addition, the OA reviews rate calculations anytime there is a significant change in the computerized information management system. The MA also reviews the residential rate components calculated by the OA for accuracy and validity whenever residential providers receive a rate increase. Although the room and board component of a residential rate is not claimed for FFP, it is still an integral factor in the calculation of a residential rate and is included in the MA review.

Further, the OA selects a representative sample of claims and conducts post-payment reviews to verify whether the services were approved in the PCP. The OA summarizes the post payment review data and provides quarterly reports to the MA of their findings and any remediation activities (on an individual and systemic basis). Remediation may include clarifying policy, retraining staff, providing technical assistance, voiding claims, increased monitoring, conducting focused reviews, or developing plans of correction, as appropriate. The OA selects a statistically valid sample from customers enrolled in the waiver using a 95% confidence level and a +/-5% margin of error and reviews 100% of the claims for the customer for services received. The OA compares the customer's PCP to services billed in order to ensure services were received as identified in the PCP. The OA ensures the provider is enrolled and approved to provide the service. The OA reviews the claims from the last SFY to ensure services were billed and paid accurately according to the waiver. The provider is notified indicating deficiencies identified and if a Corrective Action Plan is required. Annually, the OA selects a statistically valid sample (with a 95% confidence level and a +/-5% margin of error) of providers and conducts an unannounced review to ensure the corrective action plan is being followed.

When inappropriate claims are identified, the OA works with the provider to correct their billing. If the correction includes a recoupment, the collection occurs through future billings submitted by the provider until the money is recouped. If a correction can't be made by recoupment, the OA submits a request to the DHS, Bureau of Collections (BOC) to establish a collection. The BOC works with the provider until the debt is collected. The system has edits in place to adjusts billings to ensure they don't get submitted for FFP.

The MA performs a validation review based on the OA report to verify that post-payment review procedures were followed, and appropriate remediation actions were taken. The MA's validation review includes an assessment and review of the internal controls established by the OA. The MA assesses the appropriateness of established controls and performs tests to provide reasonable assurance that the established controls are followed. The MA uses the data warehouse to verify that claiming errors were corrected by crediting CMS with any applicable FFP. As a result of the validation review, the MA works with the OA to modify and strengthen internal controls as needed.

The MA has implemented oversight procedures that provide increased assurance that claims are coded and paid in accordance with the reimbursement methodology specified in the waiver. These processes enable staff to monitor the financial aspects of the waiver from a global perspective, rather than review a sample of paid claims. The MA determined that reviewing a sample of paid claims was of limited effectiveness and would not likely disclose problematic billings, patterns and/or trends.

CONTINUED IN MAIN B OPTIONAL UNDER APPENDIX I-1

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I1 Number and percent of payments that were paid for customers who were enrolled in the waiver on the date the service was delivered. N: Number of payments that were paid for customers who were enrolled in the waiver on the date the service was delivered. D: Total number of payments.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS Medical Data Warehouse

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*

☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
I2: Number and percent of payments made that were coded and paid only for services rendered as specified in the approved waiver. N: Number of payments made that were coded and paid only for services rendered as specified in the approved waiver. D: Total number of payments reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Person Centered Plans

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☒ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% confidence level with a +/- 5% margin of error*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I3 Number and percent of rates that are consistent with the approved rate methodology throughout the five-year waiver cycle. N: Number of rates that are consistent with the approved rate methodology throughout the five-year waiver cycle. D: Total number of rates.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS Medical Data Warehouse

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample***

		Confidence Interval =
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

The OA annually conducts a statistically valid review of Waiver claims to ensure the appropriate waiver reimbursement methodology was used and that it was applied correctly.

The OA also annually conducts a statistically valid review of Waiver customers to ensure the customer was Medicaid eligible on the date of service and that services were actually delivered. These desk reviews can include documentation reviews of eligibility assessments, attendance records, work logs, phone logs, travel logs, appointment schedules, progress notes, etc. If needed, phone interviews with guardians and providers may be included.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

I1: The MA will require the OA to void the federal claim for services provided prior to the customer's waiver enrollment. Remediation must be completed within 30 days.

I2: The OA will determine whether the service was coded and paid correctly and authorized in the PCP. If missing from the PCP, the PCP will be revised to include the service. If coded and/or paid incorrectly, the OA will void the federal claim and resubmit. Remediation must be completed within 30 days.

I3: The MA will require the OA to either recoup the overpayment or repay at correct rate. If necessary, it will also adjust the federal claim. Remediation must be completed within 30 days.

The OA is responsible for seeing that these individual findings are resolved. The OA provides quarterly reports of these activities to the MA. Staff of the two State agencies review the reports on a quarterly basis.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☒ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-

operational.

- (●) ***No***
- ( ) ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The public input process for this waiver amendment is detailed in Main Section 6-I.

General

All rate methodologies are established by the OA and reviewed and approved by the MA, who retains final authority over payment rates. The MA solicits public comments by means of a public notice when changes in methods and standards for establishing payment rates under the Waiver are proposed. The notice is published in accordance with Federal requirements at 42 CFR 447.205, which prescribes the content and publication criteria for the notice. Whenever rates change, a listing of all covered services and corresponding rates is made available to customers and guardians (when applicable), family members, Self-Direction Assistance providers, ISC's, and providers. Copies of rate methodologies are on file with the MA and the OA. Established rates are published on the OA's website at: https://www.dhs.state.il.us/page.aspx?item=125310.

Rates for all waiver services are reviewed on an ongoing basis by the MA and OA, at a minimum every five years. Effective, 1/1/2023, or upon CMS approval, a Regional Wage Factor is being implemented, which will allow rates to vary based on geography. A geographic differential for CILA rate methodologies for customers living and being served in the City of Chicago as well as Cook, DuPage, Kane, Lake, McHenry, and Will counties (hereafter referred to as "Chicago and collar counties is being implemented. Rates paid for waiver services do not differ based on provider except for Personal Support services. These rates negotiated between the customer and Personal Support Worker. The MA and OA work cooperatively to ensure payments are consistent with economy, efficiency, and quality of care and are sufficient to enlist enough providers. This is completed by performing rate studies and comparing states with similar demographic characteristics as Illinois.

In August 2019, the OA contracted with Guidehouse, Inc. ("Guidehouse"), to serve as a rate developer to review current rate methodologies and reimbursement levels and develop recommendations for new rate methodologies and benchmark rates for Community Integrated Living Arrangement (CILA), the State's home and community based residential waiver program for Persons with Intellectual and/or Developmental Disabilities, as well as all other services used to support a customer in a residential setting to include, but not be limited to, day habilitation services, supported employment, behavior therapy services, and supplemental services. Guidehouse relied on objective, publicly available data sources, standard administrative cost-reporting, and a provider-reported cost survey specially designed for the rate development process. The objectives of the rate study aimed to determine benchmark rates based less on providers' historical costs and more on the resources required to promote access to quality services going forward. Consequently, their approach established cost assumptions on objective national and regional benchmark cost data when available, basing assumptions on provider-reported data only when more extensive industry data was unavailable or appropriate to the settings in Illinois. The specially designed and detailed provider cost and wage survey sought data from residential and day habilitation providers on costs and wages from Fiscal Year 2018. See Rate Study, page 8 for a detailed list of information sought. The rate recommendations were published in the form of a report titled "Developmental Disabilities Services Rate Study" (hereinafter referred to as Rate Study) in November 2020. The Rate Study can be viewed at https://www.dhs.state.il.us/page.aspx?item=136098 for complete details on all that follows. The Rate Study identified benchmark rates and final recommendations beginning on page 70 of the report. The Rate Study also estimated the fiscal impact of all the recommendations beginning on page 79 of the report. Due to the significant financial impact of the recommendations, the OA has developed a multi-year implementation plan.

Beginning in August 2018 but prior to contracting with Guidehouse in August 2019, the OA established a robust stakeholder process to seek input into the rate development process which included over 100 participants representing families, customers, service providers and advocates working in seven subject matter workgroups. The workgroups were overseen by a Rates Oversight Committee comprised of stakeholders in the system. The workgroups results were presented to Guidehouse to provide direction in the rate development process. The Oversight Committee continued to meet monthly with Guidehouse throughout the entire rate development process providing insight and feedback as the work progressed. Following the completion of the Rate Study, the OA held four webinars with stakeholders to not only discuss the results of the Rate Study, but also to solicit input on the recommendations of the Rate Study that are now the subject of this renewal. In addition, the Rate Study has been a frequent topic of the OA's weekly "DDD Communications," an e-mail distributed newsletter sent to anyone who has signed up to be on the LISTSERV including providers, stakeholders, advocates, trade associations, customers, families, etc. DDD Communications can be found at: (https://www.dhs.state.il.us/page.aspx?item=78358).

The final rate report was provided to the OA, and shared with MA, the Rates Oversight Committee, waiver customers,

stakeholders, and interested parties in December 2020. A five-year timeline for implementation is planned pending appropriation via the Illinois General Assembly's budget process and subsequent approval by the Governor. Rate changes were implemented 1/1/2022 for Residential Habilitation, Supported Employment – Individual Employment Support, Supported Employment – Small Group Supports, Community Day Services, Behavior Intervention and Treatment, and Behavioral Services (Psychotherapy and Counseling). The State continues to analyze the fiscal impact of these increases. In the State's FY23 budget, the OA received additional funding from the Illinois General Assembly to further implement the Guidehouse Rate Study recommendations for Residential Habilitation. These increases are effective 1/1/2023, or upon CMS approval. The last rebasing of rates was completed by the OA in 2020 when it completed the Guidehouse Rate Study.

Request for Application (RFA) are posted on a website used by all State agencies to list contracting opportunities with the State. This website is referred to as the Illinois Procurement Bulletin (IPB). Vendors of all types can register on the IPB to do business with the state, to review requests for information or proposals, and receive updates on procurement rules and requirements. The RFA for this service used the IPB website. We believe this process is an effective means to identify all qualified and willing providers and to compare their costs.

The Illinois General Assembly reviews funding allocations on an annual basis. We cannot predict, however, how frequently the Administration and General Assembly may consider COLAs for various services.

Overview of Wages for Services effective 1/1/2023, or upon CMS approval:
Wages for Residential Habilitation, Community Day Services – On Site, Community Day Services – Off Site, Supported Employment – Individual Employment Support, and Supported Employment – Small Group Supports include an employee related expenses (ERE) factor of 25.0 - 29.9% depending on the service and the staff position. ERE includes legally required benefits such as unemployment taxes, federal insurance contributions and worker's compensation, paid time off components such as vacation, sick, personal and holiday days and other benefits such as retirement, health insurance and vision and dental insurance. See Section D.1.2, page 18, of the Rate Study for a description of what factors are included in the ERE and their calculations.

Residential Habilitation:
These rates were originally established by the OA and approved by the MA in 1994 and have been subject to proposed legislative increases over subsequent years. The rates were last updated 1/1/2022. These rates are being updated 1/1/23, or upon CMS approval.

Residential Habilitation Services: Group and individual home settings, known as Community Integrated Living Arrangements (CILA), are funded by level of support needs based on the individual's Service Score derived from the Inventory for Client and Agency Planning (ICAP). Effective 1/1/2023, or upon CMS approval, an adjustment factor is being implemented that is based on the customer's Health Care Level (HCL) as determined by their Health Risk Screening Tool (HRST). Health Care Level (HCL) is an additional factor in determining the number of DSP hours calculated for a customer in 24-Hour CILA. This factor is incorporating additional DSP time to facilitate customers in getting to and from needed medical appointments. This also implements one of the Guidehouse Rate Study recommendations. Customers with higher HCL Scores will have additional DSP time incorporated into their CILA Rate as a higher HCL score objectively measures and quantifies a customer's health need(s). There are three types of CILA services: 24-hour CILA, Host Family and Intermittent. Though Enhanced Residential is identified in the Residential Habilitation service definition, its rate methodology aligns with Community Day Services.

General Description of the three CILA Types:
For a general description of all three CILA types, please refer to Appendix C, Service Definitions. Rate Components Common to all Three CILA Types:
Program Component: The Program component of the rate methodology reimburses providers for those costs incurred in providing habilitation services and supports. Included in the program component are reimbursement for base staffing costs, Qualified Intellectual Disabilities Professional (QIDP) staffing costs, Supervisor staffing costs, supply costs, miscellaneous consultant services costs and nursing costs.

On 7/1/2022, the Direct Service Professional (DSP) funded Wage Rate was set at $16.00. The DSP rate was initially set in 1994 and increased subsequently with periodic COLAs and wage increases authorized through legislative approval. Effective 7/1/2022, the QIDP and Supervisor Wage Rates were established by using the 2018 Bureau of Labor Statistics (BLS) median wage and adjusting for present day. A 25% Employment Related Expenses (ERE) factor is calculated on

all staff wages. Hourly wages determined by BLS Occupational Statistics are adjusted annually.

The OA is further implementing recommendations in the Guidehouse Rate Study. Effective 1/1/2023, or upon CMS approval, the Direct Service Professional (DSP) funded Wage Rate will increase to $17.00 statewide and a Regional Wage Factor of 15% to $19.55 will be implemented for DSP funded Wage Rates in Chicago and collar counties. The QIDP, Supervisor and RN funded Wage Rates will be increased to the most recent Bureau of Labor Statistics (BLS) median wage. The wages are reviewed and adjusted annually using the most current BLS median wage and increased based on the percentage increase received by the DSPs in order to avoid compression in the wage bands. The same 15% Regional Wage Factor is being implemented for these job titles for people living in and being served in Chicago and collar counties. The ERE is being increased to 29.9% for DSPs and ERE from 24.9% to 28.1% for the other named job titles as specified in the Guidehouse Rate Study (See D.1.2, Table 7).

CONTINUED IN MAIN B OPTIONAL UNDER APPENDIX I-2-a

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Provider Payment

Fee-for-Service providers are paid by the OA. Providers may bill Medicaid directly.

Waiver funding is appropriated to the OA primarily from the State's General Revenue Fund.

The OA maintains a computerized payment system that includes PCP authorization for each customer, payments to provider agencies, units of service delivered to each eligible customer, and payment and claiming rates per unit of service.

The OA authorizes services in advance of service delivery. The provider and/or the customer, if the customer is receiving Personal Support Worker services, report and certify that the service was delivered, and the OA approves payment for the service. A voucher document is utilized in this payment process and constitutes a legal agreement between the OA and the provider.

The OA payment system contains edits to ensure that payments are made only when the customer is authorized for the program services delivered, via the PCP that specifies the program services, the provider of the program services, the amount the services authorized, providers that are properly enrolled for the services delivered, and that payment is made at the correct payment rate.

The OA's software system processes all parts of the billings and claims but the State's Comptroller creates the payment vouchers to pay the provider agencies. There is a three-party Medicaid Waiver provider agreement (HFS 1413) between the provider, the OA and the MA.

Payments for some services, such as customer-directed Personal Support services where the customer exercises employer authority, flow through the Financial Management Service (FMS) entity and are paid and transmitted to the OA system for claims processing.

OA Claims Processing

Information from the OA's computerized payment system feeds into the computerized claiming system that contains edits to ensure that the customer has been determined to meet the ICF/IID level of care prior to the date of service. The OA claiming system picks up the established claiming rate and compares it with the actual payment rate; the lower of the two is the amount claimed. Finally, the OA claiming system subtracts from the Waiver claim the spenddown obligation of each customer, if any (available on a monthly extract from the MA's MMIS system).

Valid billing submissions are submitted to the MA on a weekly basis, to determine Medicaid eligibility. The MA then returns a weekly file to the OA with an OBRA indicator code for all those customers who met the eligibility criteria. Customers who were not returned with an OBRA indicator code are researched by the OA staff and re-submitted. If issues are corrected, the MA will provide the OA OBRA indicator code. All billings that were accepted by the MA from OA with the OBRA indicator code are eligible for federal financial participation. Federal financial claiming is submitted by MA.

Payments are made by the State of Illinois Comptroller's Office from OA appropriation. The OA then submits the amount of expenditures for Medicaid eligible customers to the MA for submission of federal financial participation.

MA's Claims Processing

The OA Waiver claiming data are transmitted to the MA via a weekly computer tape exchange. The Waiver subsection of the MMIS matches the customer against the recipient eligibility file to ensure Medicaid eligibility on the date of service and verifies the provider is enrolled as a Waiver provider with the MA. The Waiver subsection includes edits for Waiver claims that conflict with other Waiver and hospital, nursing home, hospice facility, or ICF/IID claims and rejects Waiver claims that are duplicative or incompatible. MMIS includes edits for waiver claims that conflict with other waivers, hospitals, nursing home, hospice facilities, or institutional claims, and rejects waiver claims that are duplicative or incompatible.

Federal matching funds are deposited into the State's General Revenue Fund. A small portion of the federal matching

funds is deposited into a dedicated fund to be used to fund community services for customers with developmental disabilities.

The State was approved for a Good Faith Effort exemption request for the implementation of an open/hybrid model Electronic Visit Verification (EVV) on November 21, 2019. On June 3, 2021, the MA posted a Request for Proposal (RFP) to secure the open/hybrid model Electronic Visit Verification (EVV). The winning bidder has been selected. The state anticipates the EVV system will be operational by the end of calendar year 2022. This system will be used for the personal care services (PCS) and Home Health Care Services (HHCS) as defined in the 21st Century Cures Act. PCS are defined as Activities of Daily Living (ADL), such as movement, bathing, dressing, toileting, transferring, and personal hygiene and Instrumental Activities of Daily Living (IADL), such as meal preparation, money management, shopping, and telephone use. HHCS are defined as personal care services or home health care services requiring an in-home visit by a provider that are provided under a state plan or 1915c waiver. Customers have the choice to continue to use the current EVV system operated by the OA or change to the open/hybrid EVV model system that will be maintained by the MA. To ensure financial integrity and accountability, EVV will allow the state to monitor and reduce in unauthorized services, improve the quality of services to customers, and reduce fraud, waste and abuse.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- (●) ***No. state or local government agencies do not certify expenditures for waiver services.***
- ( ) ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's*

approved service plan; and, (c) the services were provided:

Provider billings are validated by the OA to verify the effective date of each waiver service authorized in the customers PCP and the customer's level of care eligibility. Providers are required to certify billings are true and accurate through the ROCS billing system which transmits the billing information to the Community Reimbursement Subsystem (CRS). The CRS has edits in place which conduct checks to ensure the customer has Medicaid coverage on the date the service is provided and billed, and the customer is authorized to receive the service.

Provider billings are validated by the OA to verify the effective date of the customer's eligibility and authorization for services according to the approved PCP. Customers also sign time sheets to verify that services were performed in accordance with the PCP. If inappropriate billing is discovered, the claim is adjusted or voided by the OA to reduce the state's claim for FFP. The OA will contact the provider to collect any overpayment. The OA will also void or adjust any claims related to the restitution. When inappropriate billings are identified, the OA either ensures the provider voids the billing or the OA voids the billing itself in the electronic payment system. This initiates a recoupment of overpayments. This action in turn automatically voids the claim for Federal Financial Participation.

Paid claims are passed through to the MA and MMIS processing edits are initiated for Medicaid and waiver eligibility. Lastly, the MA performs post-payment personal plan and financial reviews.

Oversight to ensure that appropriate services were provided occurs through the OA's computer system. The OA's computer system generates applicable rates and service authorizations according to the waiver program parameters for which the customer is authorized to participate. Each customer's service authorization(s) of which some are provider agency specific where only the specified provider can bill and receive payment and others are generic where any qualified and enrolled provider can bill and be paid are transmitted from the OA's computer system to the OA's Community Reimbursement Sub-system (CRS). The OA's computer system can either produce individualized or statewide rates as set by the OA's rate setting methodologies. The OA's computer system also transmits the individualized or statewide rates to the OA's (CRS) which maintains a complete historical record of every customer's authorization(s) for services and rates.

CRS also contains each provider's eligibility to provide services and what services the provider is eligible to provide, bill and be paid for. Each provider or provider agency submits billing through the OA's Reporting of Community Services (ROCS) system. ROCS reporting from each provider or provider agency includes the customer's information of the first, last and middle initial of the customer's name, Social Security Number (SSN), Recipient Identification Number (RIN), and Date of Birth (DOB). The provider or provider agency also reports specific bill codes for each service delivered, quantity of services delivered and bill rate. All ROCS billing is transmitted to the CRS. The CRS batch processes all ROCS billing on a weekly basis. The CRS has edits which check for the customer's identity against the customer's information in CRS. The customer's Medicaid eligibility on the day services were delivered and being billed for, the customer is authorized for the service being billed and the service was authorized for the date service(s) are being billed. The CRS also compares the provider's billing rate against either the statewide billing rate or the customer's authorized individualized rate for the applicable service and bill code.

The CRS adjudicates all provider billing based on the customer's eligibility for services on the date services were delivered by the provider or provider agency. The CRS performs edit checks that the provider or provider agency is eligible to deliver the service being billed. CRS also adjudicates the payment for services based on the OA's authorized rate for the customer for each service. CRS rejects and does not pay for any services which do not pass all of the above listed edits including services provided before or after a customer's service authorization for each service.

Other edits ensure appropriate billing is submitted by the provider or provider agency include that the CRS reject billing for services prior to the customer's determined date of eligibility for DD services by the ISC.

Another safeguard for all provider billings is that CRS will reject any billing if the billing was previously submitted, adjudicated and paid. Provider agencies cannot bill over the authorized number of units for a day or month of service nor can a provider or provider agency bill over the annually authorized number of units of any specific service for the customer.

Provider claims are further validated by applying MMIS processing edits and by conducting OA post-payment reviews. See also Appendix I-1 for additional information on post-payment reviews. Through post-payment reviews, the OA, based on a representative sample of claims, confirms that services were in accordance with the PCP.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

◉ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Under an interagency agreement with the Medicaid Agency, the Operating Agency makes payments from a central computer system. Providers may bill the MA directly. On a weekly basis, Waiver claims are edited and sent to the Medicaid Agency for Medicaid claiming. The audit trail is established through State agency approved rates, person centered plan authorization, documentation of service delivery, and computerized payment and claiming systems cross-matched with the Medicaid Agency, MMIS system.

The OA performs a post payment review, based on a statistically valid representative sample of waiver claims (with a 95% confidence level and a +/-5% margin of error). The post payment review looks at whether the services were specified in the person centered plan. The OA reviews a statistically valid representative sample of claims (with a 95% confidence level and a +/-5% margin of error) to determine whether the individual was eligible on the date of services. The OA reviews a statistically valid representative sample of claims (with a 95% confidence level and a +/-5% margin of error) of waiver claims to determine whether the rates paid are in accordance with the reimbursement methodology. The OA submits a quarterly report to the MA with their findings and remediation activities. The MA conducts a validation review based on the quarterly reports to verify that the OA followed their post payment review procedures and verifies that appropriate remediation actions were taken.

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Under an interagency agreement with the MA, the OA or a Financial Management Service (FMS) entity, as described in Appendix E, makes payments directly to providers of waiver services. The OA then sends electronic claims via computer tape based on the paid services to the MA for further adjudication and Federal Waiver reimbursement purposes.

The limited fiscal agent is Avenues to Consumer Employer Services and $supports (ACES$) a function of the OA. Services paid through the FMS entity are limited to Personal Support Worker (PSW) services.

ACES$ developed a payroll system for PSWs. The customer or their identified Employer of Record (EOR) must sign/approve timesheets to verify the hours worked. The timesheets are sent to ACES$ via mail, e-mail, fax or online portal. ACES$'s payroll system validates the submitted timesheets, confirms the PSW is authorized to provide services to the customer, ensures the hours worked are within the approved service authorization, and the appropriate rate is assigned. The ACES$ operated payroll system pays PSWs twice monthly. The payroll system withholds unemployment, FICA, and other deductions as requested by the PSW.

The OA passes the detail expenditure data weekly to the MA. The MA is the single Statewide Medicaid claiming agency for the State of Illinois. The data is fed into the Medicaid Management Information System (MMIS) and is subject to edits to ensure the information provided is accurate and that the services/providers are eligible for federal match under Title XIX. Should any claims have inaccurate information, those claims are rejected by the system and a file of the rejected claims is passed back to the OA for their review. Claims that pass through the system without error filter down to the MARS reporting unit. The MARS unit is responsible for generating the reports to the Bureau of Federal Finance (BFF) who use the reports to claim Medicaid expenditure data quarterly on the CMS 64. MARS also has a series of edits and codes that are used to filter data to ensure accuracy and to determine to what program the expenditure should be reported. The BFF report the expenditures on the CMS 64 on a quarterly basis 30 days after the quarter ends.
Federal Draws from the Medicaid Grant – In accordance with the Cash Management Improvement Act (CMIA), the BFF draws down federal monies from the Title XIX grant for the waiver on a weekly basis and deposits the funds into the General Revenue Fund (GRF). The amount to be drawn is an estimate derived by using historical expenditure data. Once the CMS 64 is completed at the end of the quarter, the BFF reconciles the estimated cash draw to the actual expenditures reported on the CMS 64. The reconciling expenditure amount is either added to or subtracted from the grant award depending on whether the adjustment is over or under the original estimated amount.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- (●) ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ( ) ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- (●) ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ( ) ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ( ) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment *(6 of 7)*

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***

○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment *(7 of 7)*

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

◉ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

The Operating Agency (OA)- Department of Human Services, Division of Developmental Disabilities.

ii. Organized Health Care Delivery System. *Select one:*

◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have

free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- [ ] ***Appropriation of State Tax Revenues to the State Medicaid agency***

☒ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Funds are directly appropriated by the Illinois General Assembly from the General Revenue Fund to the Operating Agency. The funds are not transferred.

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

  Check each that applies:

  - [ ] ***Health care-related taxes or fees***
  - [ ] ***Provider-related donations***
  - [ ] ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- (●) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The OA sets individualized rates for a participant in a Residential Habilitation setting based on a rate methodology that is comprised of the following components:

-Room and Board Component - reimburses community providers for keeping a home in normal operation.
-Program Component - reimburses community providers for providing habilitation services and supports, including training, protective oversight, supervision and other assistance to customers with a developmental disability living in a residential setting.
-Transportation Component - reimburses community providers for providing general transportation to and from community locations that are not day program sites or places where Medicaid State Plan services are delivered.
-Administration Component - reimburses community providers for general staff supervision and overhead related to the delivery of residential supports.
-Individual Supports Component - reimburses community providers for supports that are specific to a customer's needs that are not covered elsewhere.
The OA determines waiver claims for Residential Habilitation services based on the Program, Transportation, Administration, and Individual Supports components of the rates. The Room and Board Component is excluded when calculating waiver claims.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	56016.06	3042.43	59058.49	141093.33	3540.63	144633.96	85575.47
2	59054.57	3133.70	62188.27	150264.40	3735.37	153999.77	91811.50
3	61743.20	3227.72	64970.92	160031.59	3940.81	163972.40	99001.48
4	64701.31	3324.55	68025.86	170433.64	4157.56	174591.20	106565.34

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
5	67825.25	3424.28	71249.53	181511.82	4386.22	185898.04	114648.51

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		ICF/IID
Year 1	25250	25250
Year 2	25859	25859
Year 3	26479	26479
Year 4	27115	27115
Year 5	27766	27766

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay (ALOS) has been projected based upon enrollment data in MMIS during state fiscal years 2016 through 2020 and projected phase-in and phase-out projections. The calculation for ALOS for each waiver year is determined by dividing the number of days for customers on the waiver by the unduplicated customer count (8,395,770/24,500).

The phase-in and phase-out projections are detailed in Attachment #1 of Appendix B-3-d.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D for the five year waiver cycle was projected in the following manner:

Unduplicated customers for each waiver service:
IL.0350.R5.00—Renewal 7/1/2022
The percent of total unduplicated customers receiving each waiver service was based upon paid claims in MMIS during state fiscal years 2016 through 2020.

Factor D was calculated by counting the number of unique customers in MMIS enrolled in the waiver from January 2017 through September 2021 and projected all the renewal waiver years based on observed historical levels. Additionally, overall growth assumptions based on historical experience for customers moving on and off the waiver. The noted variance occurs because we round the number of customers to the nearest integer. For services with low utilization, rounding can have a noticeable impact on effective trend.

IL.0350.R5.01—Amendment 1/1/2023
For Residential Habilitation, the estimate for WY 1 Unduplicated customers was developed by using current approved and/or placed rates as of June 30, 2022 (11,086 rates approved) according to the DHS website https://www.dhs.state.il.us/page.aspx?item=145602. An 11.2% increase was applied to reflect a proportional increase for WY 1 unduplicated participants. Residential Habilitations users were increased proportionally for WY 2 – WY 5.

For all other services, the assumption and methodology are consistent with the waiver renewal (IL.0350.R5.00) except that we assumed a minimum of 10 users for each service in order to avoid the need for an amendment in the future should the number of users change by an amount that would have an immaterial impact to the total cost of waiver services. When an assumed number of users of a service is a percentage of unduplicated recipients, the number of users of a service increases proportionally with the number of unduplicated recipients.

Average units per customer:
IL.0350.R5.00—Renewal 7/1/2022
The average units per customer for each waiver service in waiver year 1 is based upon paid claims in MMIS during state fiscal years 2016 through 2020. The average units per customer for waiver years 2 through 5 were calculated by multiplying the prior year average units per customer by the change in ALOS between waiver years. As the ALOS is projected to be unchanged for each of the waiver years, the average units per customer remain unchanged.

Residential Habilitation contains four procedure code combinations. Each is counted "Per Day", but customers with intensive needs are using two of these in a day.

IL.0350.R5.01—Amendment 1/1/2023
Changes were made to the average units per user for the Residential Habilitation service. The Residential Habilitation waiver category contains 24-Hour CILA, which is billed daily, and Intermittent CILA, which is billed hourly. We assumed the average units per user based on claims in MMIS for SFY 2018 and SFY 2019 for these two services. Waiver Year 2 includes an extra day because of a leap year.

Average cost per unit:
IL.0350.R5.00—Renewal 7/1/2022
The average cost per unit is based on the current fee schedules for Adult Day Service, Community Day Service, Self-Direction Assistance, Temporary Assistance, Occupational Therapy, Physical Therapy, Speech Therapy, Skilled Nursing, Training and Counseling Services for Unpaid Caregivers services. Cost per unit for Behavior Intervention and Treatment and Behavioral Services (Psychotherapy and Counseling) are based upon the statewide benchmark rates published in the Developmental Disability Services Guidehouse Rate Study, dated November 30, 2020. Cost per unit for other services are based upon paid claims in MMIS during state fiscal years 2016 through 2020.

IL.0350.R5.01—Amendment 1/1/2023
The average cost per unit was updated for 24 Hour Stabilization Services, Adult Day Service (ADS), Emergency Home Response Services (EHRS), Self-Direction Assistance, Occupational Therapy (OT), Physical Therapy (PT), Speech Therapy (ST), Skilled Nursing, Supported Employment – Individual Employment Support (SEI), and

Supported Employment – Small Group Support (SEG) based upon reimbursement changes effective in 1/1/2023. WY 1 estimates were developed by weighting estimates with January 2023 rate increases using projected enrollment. For WY 2 through WY 5, we maintained the same cost per unit trend assumptions.

As stated previously, Residential Habilitation is a composite of 24-Hour CILA and Intermittent CILA. Estimates for the total WY 1 Residential Habilitation expenditures were developed by using claims in MMIS for SFY 2018 and SFY 2019 for these two services and divided by the average units per user to develop an average cost per service.

The Community Day Service waiver service includes On Site, Off Site, and Enhanced Residential sub-services. In the waiver renewal (IL.0350.R5.00), Enhanced Residential utilizers were mistakenly excluded from the composite Community Day Service calculation. For this amendment (IL.0350.R5.01), we assumed 2,000 of the Community Day Service utilizers received the Enhanced Residential service and allocated the remaining users as 60% On Site and 40% Off Site. The WY 1 composite average cost per unit was developed by blending the revised first half of WY 1 composite with the new second half of WY1 composite. For WY 2 through WY 5, we maintained the same cost per unit trend assumptions as the waiver renewal (IL.0350.R5.00).

ii. ***Factor D' Derivation.*** *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Estimates for Factor D' are based upon paid claims in MMIS during state fiscal years 2016 through 2020 and was trended to increase at a rate of approximately 3% per year.

State fiscal year 2020 Factor D' spending per capita, as reported in the SFY 2020 372 report, were summarized for non-waiver services provided during the waiver year to individuals enrolled in the waiver. Future waiver years were projected based on the trends observed in the 372 reports for SFY2017 – SFY 2020.

Factor D' and Factor G' were developed by reviewing SFY 2018 – SFY 2020 historical experience and developing trend rates. We have observed higher historical trends for the institutional population, and we applied a 5.5% annual trend to G' services and a 3.0% annual trend to D' services. Population mix differences (e.g. dual-eligible vs. Medicaid only, managed care vs FFS) have a significant influence on observed Prime trend rates.

iii. ***Factor G Derivation.*** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Estimates for Factor G are based upon paid claims in MMIS during state fiscal years 2018 through 2020 for fee-for-service institutional customers ages 18 and older with a comparable level of care and was trended to increase at a rate of approximately 6.5% per year.

Factor G spending per capita, using FFS claims for institutional customers ages 18 and older with a comparable level of care were summarized for each historical waiver year SFY 2018 through SFY 2020. A 6.5% annual trend was selected based upon the annual per capita institutional cost for the period of SFYs 2016 through 2020. Factor G for each projected waiver year is this expenditure value, divided by the number of unduplicated customers with a non-zero intermediate care facility expenditures.

iv. ***Factor G' Derivation.*** *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Estimates for Factor G' are based upon paid claims in MMIS during state fiscal years 2018 through 2020 for fee-for-service institutional customers ages 18 and older with a comparable level of care and was trended to increase at a rate of approximately 5.5% per year.

Factor G' spending per capita, using FFS claims experience for institutional customers ages 18 and older with a comparable level of care were summarized for each historical waiver year SFY 2018 through SFY 2020. A 5.5% annual trend was selected based upon the annual per capita non-institutional cost for state fiscal years 2018 through 2020. Future waiver years were projected on Factor G' expenditure per unduplicated customer trend from state fiscal years 2016-2020. Factor G' is all such allowable non-waiver related expenditures divided by the number of unique customers during the waiver year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Service	
Community Day Services	
Residential Habilitation	
Occupational Therapy (Extended Medicaid State Plan)	
Physical Therapy (Extended Medicaid State Plan)	
Speech Therapy (Extended Medicaid State Plan)	
Self Direction Assistance	
24-Hour Stabilization Services	
Adaptive Equipment	
Assistive Technology	
Behavior Intervention and Treatment	
Behavioral Services (Psychotherapy and Counseling)	
Emergency Home Response Services (EHRS)	
Home Accessibility Modifications	
Non-Medical Transportation	
Personal Support	
Remote Support	
Skilled Nursing	
Supported Employment - Individual Employment Support	
Supported Employment – Small Group Supports	
Temporary Assistance	
Training and Counseling Services for Unpaid Caregivers	
Vehicle Modification	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						123704.35
Adult Day Service	Hour	11	698.50	16.10	123704.35	
Community Day Services Total:						260411524.10
Community Day Services	Hour	18356	906.50	15.65	260411524.10	
Residential Habilitation Total:						911268181.17
Residential Habilitation	Per Day	12326	324.20	228.04	911268181.17	
Occupational Therapy (Extended Medicaid State Plan) Total:						44128.79
Occupational Therapy (Extended Medicaid State Plan)	Hour	73	8.20	73.72	44128.79	
Physical Therapy (Extended Medicaid State Plan) Total:						14744.00
Physical Therapy (Extended Medicaid State Plan)	Hour	16	12.50	73.72	14744.00	
Speech Therapy (Extended Medicaid State Plan) Total:						25949.44
Speech Therapy (Extended Medicaid State Plan)	Hour	88	4.00	73.72	25949.44	
Self Direction Assistance Total:						12759516.40
Self Direction Assistance	Hour	8240	30.50	50.77	12759516.40	
24-Hour Stabilization Services Total:						5223075.00
24-Hour Stabilization Services	Day	30	162.50	1071.40	5223075.00	
Adaptive Equipment Total:						41400.00
Adaptive Equipment	Per Item	23	1.20	1500.00	41400.00	
Assistive Technology Total:						39600.00
Assistive Technology					39600.00	

GRAND TOTAL:	1414405514.50
Total Estimated Unduplicated Participants:	25250
Factor D (Divide total by number of participants):	56016.06
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Per Item	22	1.20	1500.00		
Behavior Intervention and Treatment Total:						30343105.26
Behavior Intervention and Treatment	Hour	8268	39.50	92.91	30343105.26	
Behavioral Services (Psychotherapy and Counseling) Total:						2363914.70
Behavioral Services (Psychotherapy and Counseling)	Hour	2030	23.00	50.63	2363914.70	
Emergency Home Response Services (EHRS) Total:						2726.94
Emergency Home Response Services (EHRS)	Per Month	10	9.40	29.01	2726.94	
Home Accessibility Modifications Total:						899080.00
Home Accessibility Modifications	Per Item	112	1.90	4225.00	899080.00	
Non-Medical Transportation Total:						125580.00
Non-Medical Transportation	Per Item	195	46.00	14.00	125580.00	
Personal Support Total:						179004124.30
Personal Support	Hour	9481	1046.00	18.05	179004124.30	
Remote Support Total:						120000.00
Remote Support	Monthly	40	12.00	250.00	120000.00	
Skilled Nursing Total:						19550.85
Skilled Nursing	Hour	17	27.50	41.82	19550.85	
Supported Employment - Individual Employment Support Total:						8926240.62
Supported Employment - Individual Employment Support	hour	1119	202.00	39.49	8926240.62	
Supported Employment – Small Group Supports Total:						1657319.62

GRAND TOTAL:	1414405514.50
Total Estimated Unduplicated Participants:	25250
Factor D (Divide total by number of participants):	56016.06
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment – Small Group Supports	Hour	507	287.50	11.37	1657319.62	
Temporary Assistance Total:						495790.02
Temporary Assistance	Hour	99	241.00	20.78	495790.02	
Training and Counseling Services for Unpaid Caregivers Total:						1258.94
Training and Counseling Services for Unpaid Caregivers	Hour	10	3.80	33.13	1258.94	
Vehicle Modification Total:						495000.00
Vehicle Modification	Per Item	33	1.00	15000.00	495000.00	
				GRAND TOTAL:		1414405514.50
				Total Estimated Unduplicated Participants:		25250
				Factor D (Divide total by number of participants):		56016.06
				Average Length of Stay on the Waiver:		343

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						154592.02
Adult Day Service	Hour	11	698.50	20.12	154592.02	
Community Day Services Total:						277587904.23
Community Day Services	Hour	18798	906.50	16.29	277587904.23	
Residential Habilitation Total:						994786958.89
Residential Habilitation	Per Day	12623	325.10	242.41	994786958.89	
				GRAND TOTAL:		1527092249.79
				Total Estimated Unduplicated Participants:		25859
				Factor D (Divide total by number of participants):		59054.57
				Average Length of Stay on the Waiver:		343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Occupational Therapy (Extended Medicaid State Plan) Total:						**68368.16**
Occupational Therapy (Extended Medicaid State Plan)	Hour	74	8.20	112.67	**68368.16**	
Physical Therapy (Extended Medicaid State Plan) Total:						**23942.38**
Physical Therapy (Extended Medicaid State Plan)	Hour	17	12.50	112.67	**23942.38**	
Speech Therapy (Extended Medicaid State Plan) Total:						**40561.20**
Speech Therapy (Extended Medicaid State Plan)	Hour	90	4.00	112.67	**40561.20**	
Self Direction Assistance Total:						**13394549.58**
Self Direction Assistance	Hour	8439	30.50	52.04	**13394549.58**	
24-Hour Stabilization Services Total:						**5446593.75**
24-Hour Stabilization Services	Day	30	162.50	1117.25	**5446593.75**	
Adaptive Equipment Total:						**42435.00**
Adaptive Equipment	Per Item	23	1.20	1537.50	**42435.00**	
Assistive Technology Total:						**40590.00**
Assistive Technology	Per Item	22	1.20	1537.50	**40590.00**	
Behavior Intervention and Treatment Total:						**31531616.02**
Behavior Intervention and Treatment	Hour	8467	39.50	94.28	**31531616.02**	
Behavioral Services (Psychotherapy and Counseling) Total:						**2456359.29**
Behavioral Services (Psychotherapy and Counseling)	Hour	2079	23.00	51.37	**2456359.29**	
Emergency Home Response Services (EHRS) Total:						**2820.00**

GRAND TOTAL:	**1527092249.79**
Total Estimated Unduplicated Participants:	**25859**
Factor D (Divide total by number of participants):	**59054.57**
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Home Response Services (EHRS)	Per Month	10	9.40	30.00	2820.00	
Home Accessibility Modifications Total:						938014.46
Home Accessibility Modifications	Per Item	114	1.90	4330.63	938014.46	
Non-Medical Transportation Total:						130078.34
Non-Medical Transportation	Per Item	199	46.00	14.21	130078.34	
Personal Support Total:						187898210.00
Personal Support	Hour	9710	1046.00	18.50	187898210.00	
Remote Support Total:						168000.00
Remote Support	Monthly	56	12.00	250.00	168000.00	
Skilled Nursing Total:						20817.78
Skilled Nursing	Hour	17	27.50	44.53	20817.78	
Supported Employment - Individual Employment Support Total:						9555989.76
Supported Employment - Individual Employment Support	hour	1146	202.00	41.28	9555989.76	
Supported Employment – Small Group Supports Total:						1774136.62
Supported Employment – Small Group Supports	Hour	519	287.50	11.89	1774136.62	
Temporary Assistance Total:						518434.38
Temporary Assistance	Hour	102	241.00	21.09	518434.38	
Training and Counseling Services for Unpaid Caregivers Total:						1277.94
Training and Counseling Services for Unpaid Caregivers	Hourly	10	3.80	33.63	1277.94	

GRAND TOTAL:	1527092249.79
Total Estimated Unduplicated Participants:	25859
Factor D (Divide total by number of participants):	59054.57
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modification Total:						**510000.00**
Vehicle Modification	Per item	34	1.00	15000.00	**510000.00**	
			GRAND TOTAL:			**1527092249.79**
			Total Estimated Unduplicated Participants:			**25859**
			Factor D (Divide total by number of participants):			**59054.57**
			Average Length of Stay on the Waiver:			343

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						**156897.07**
Adult Day Service	Hour	11	698.50	20.42	**156897.07**	
Community Day Services Total:						**288435581.81**
Community Day Services	Hour	19249	906.50	16.53	**288435581.80**	
Residential Habilitation Total:						**1079836178.66**
Residential Habilitation	Per Day	12926	324.20	257.68	**1079836178.66**	
Occupational Therapy (Extended Medicaid State Plan) Total:						**71262.92**
Occupational Therapy (Extended Medicaid State Plan)	Hour	76	8.20	114.35	**71262.92**	
Physical Therapy (Extended Medicaid State Plan) Total:						**24299.38**
Physical Therapy (Extended Medicaid State	Hour	17	12.50	114.35	**24299.38**	
			GRAND TOTAL:			**1634898165.02**
			Total Estimated Unduplicated Participants:			**26479**
			Factor D (Divide total by number of participants):			**61743.20**
			Average Length of Stay on the Waiver:			343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Plan)						
Speech Therapy (Extended Medicaid State Plan) Total:						**42080.80**
Speech Therapy (Extended Medicaid State Plan)	Hour	92	4.00	114.35	**42080.80**	
Self Direction Assistance Total:						**13920737.41**
Self Direction Assistance	Hour	8641	30.50	52.82	**13920737.41**	
24-Hour Stabilization Services Total:						**5628146.88**
24-Hour Stabilization Services	Day	31	162.50	1117.25	**5628146.88**	
Adaptive Equipment Total:						**45387.07**
Adaptive Equipment	Per Item	24	1.20	1575.94	**45387.07**	
Assistive Technology Total:						**43495.94**
Assistive Technology	Per Item	23	1.20	1575.94	**43495.94**	
Behavior Intervention and Treatment Total:						**32770475.85**
Behavior Intervention and Treatment	Hour	8670	39.50	95.69	**32770475.85**	
Behavioral Services (Psychotherapy and Counseling) Total:						**2552649.71**
Behavioral Services (Psychotherapy and Counseling)	Hour	2129	23.00	52.13	**2552649.71**	
Emergency Home Response Services (EHRS) Total:						**2820.00**
Emergency Home Response Services (EHRS)	Per Month	10	9.40	30.00	**2820.00**	
Home Accessibility Modifications Total:						**986765.25**
Home Accessibility					**986765.25**	

GRAND TOTAL:	**1634898165.02**
Total Estimated Unduplicated Participants:	**26479**
Factor D (Divide total by number of participants):	**61743.20**
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Modifications	Per Item	117	1.90	4438.89		
Non-Medical Transportation Total:						135317.28
Non-Medical Transportation	Per Item	204	46.00	14.42	135317.28	
Personal Support Total:						197191166.88
Personal Support	Hour	9943	1046.00	18.96	197191166.88	
Remote Support Total:						192000.00
Remote Support	Monthly	64	12.00	250.00	192000.00	
Skilled Nursing Total:						22374.00
Skilled Nursing	Hour	18	27.50	45.20	22374.00	
Supported Employment - Individual Employment Support Total:						9936501.20
Supported Employment - Individual Employment Support	hour	1174	202.00	41.90	9936501.20	
Supported Employment – Small Group Supports Total:						1841109.75
Supported Employment – Small Group Supports	Hour	531	287.50	12.06	1841109.75	
Temporary Assistance Total:						536620.24
Temporary Assistance	Hour	104	241.00	21.41	536620.24	
Training and Counseling Services for Unpaid Caregivers Total:						1296.94
Training and Counseling Services for Unpaid Caregivers	Hourly	10	3.80	34.13	1296.94	
Vehicle Modification Total:						525000.00
Vehicle Modification	Per item	35	1.00	15000.00	525000.00	

GRAND TOTAL:	1634898165.02
Total Estimated Unduplicated Participants:	26479
Factor D (Divide total by number of participants):	61743.20
Average Length of Stay on the Waiver:	343

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						159278.95
Adult Day Service	Hour	11	698.50	20.73	159278.96	
Community Day Services Total:						299840611.84
Community Day Services	Hour	19712	906.50	16.78	299840611.84	
Residential Habilitation Total:						1175378268.79
Residential Habilitation	Per Day	13236	324.20	273.91	1175378268.79	
Occupational Therapy (Extended Medicaid State Plan) Total:						74238.37
Occupational Therapy (Extended Medicaid State Plan)	Hour	78	8.20	116.07	74238.37	
Physical Therapy (Extended Medicaid State Plan) Total:						26115.75
Physical Therapy (Extended Medicaid State Plan)	Hour	18	12.50	116.07	26115.75	
Speech Therapy (Extended Medicaid State Plan) Total:						44106.60
Speech Therapy (Extended Medicaid State Plan)	Hour	95	4.00	116.07	44106.60	
Self Direction Assistance Total:						14469044.14
Self Direction Assistance	Hour				14469044.14	

GRAND TOTAL:	1754376012.98
Total Estimated Unduplicated Participants:	27115
Factor D (Divide total by number of participants):	64701.31
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		8849	30.50	53.61		
24-Hour Stabilization Services Total:						5809700.00
24-Hour Stabilization Services	Day	32	162.50	1117.25	5809700.00	
Adaptive Equipment Total:						46521.79
Adaptive Equipment	Per Item	24	1.20	1615.34	46521.79	
Assistive Technology Total:						46521.79
Assistive Technology	Per Item	24	1.20	1615.34	46521.79	
Behavior Intervention and Treatment Total:						34054631.91
Behavior Intervention and Treatment	Hour	8878	39.50	97.11	34054631.91	
Behavioral Services (Psychotherapy and Counseling) Total:						2652406.00
Behavioral Services (Psychotherapy and Counseling)	Hour	2180	23.00	52.90	2652406.00	
Emergency Home Response Services (EHRS) Total:						2820.00
Emergency Home Response Services (EHRS)	Per Month	10	9.40	30.00	2820.00	
Home Accessibility Modifications Total:						1037368.08
Home Accessibility Modifications	Per Item	120	1.90	4549.86	1037368.08	
Non-Medical Transportation Total:						140748.96
Non-Medical Transportation	Per Item	209	46.00	14.64	140748.96	
Personal Support Total:						207022897.44
Personal Support	Hour	10181	1046.00	19.44	207022897.44	

GRAND TOTAL:	1754376012.98
Total Estimated Unduplicated Participants:	27115
Factor D (Divide total by number of participants):	64701.31
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Remote Support Total:						204000.00
Remote Support	Monthly	68	12.00	250.00	204000.00	
Skilled Nursing Total:						22710.60
Skilled Nursing	Hour	18	27.50	45.88	22710.60	
Supported Employment - Individual Employment Support Total:						10326454.12
Supported Employment - Individual Employment Support	hour	1202	202.00	42.53	10326454.12	
Supported Employment – Small Group Supports Total:						1915900.00
Supported Employment – Small Group Supports	Hour	544	287.50	12.25	1915900.00	
Temporary Assistance Total:						560351.51
Temporary Assistance	Hour	107	241.00	21.73	560351.51	
Training and Counseling Services for Unpaid Caregivers Total:						1316.32
Training and Counseling Services for Unpaid Caregivers	Hourly	10	3.80	34.64	1316.32	
Vehicle Modification Total:						540000.00
Vehicle Modification	Per item	36	1.00	15000.00	540000.00	
				GRAND TOTAL:		1754376012.98
				Total Estimated Unduplicated Participants:		27115
				Factor D (Divide total by number of participants):		64701.31
				Average Length of Stay on the Waiver:		343

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:						176357.28
Adult Day Service	Hour	12	698.50	21.04	176357.28	
Community Day Services Total:						311609873.57
Community Day Services	Hour	20185	906.50	17.03	311609873.58	
Residential Habilitation Total:						1279461193.96
Residential Habilitation	Per Day	13554	324.20	291.17	1279461193.96	
Occupational Therapy (Extended Medicaid State Plan) Total:						77283.36
Occupational Therapy (Extended Medicaid State Plan)	Hour	80	8.20	117.81	77283.36	
Physical Therapy (Extended Medicaid State Plan) Total:						26507.25
Physical Therapy (Extended Medicaid State Plan)	Hour	18	12.50	117.81	26507.25	
Speech Therapy (Extended Medicaid State Plan) Total:						45710.28
Speech Therapy (Extended Medicaid State Plan)	Hour	97	4.00	117.81	45710.28	
Self Direction Assistance Total:						15039538.41
Self Direction Assistance	Hour	9061	30.50	54.42	15039538.41	
24-Hour Stabilization Services Total:						5991253.12
24-Hour Stabilization Services	Day	33	162.50	1117.25	5991253.12	
Adaptive Equipment Total:						49671.60
Adaptive Equipment	Per Item	25	1.20	1655.72	49671.60	

GRAND TOTAL:	1883235902.39
Total Estimated Unduplicated Participants:	27766
Factor D (Divide total by number of participants):	67825.25
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology Total:						47684.74
Assistive Technology	Per Item	24	1.20	1655.72	47684.74	
Behavior Intervention and Treatment Total:						35396247.04
Behavior Intervention and Treatment	Hour	9092	39.50	98.56	35396247.04	
Behavioral Services (Psychotherapy and Counseling) Total:						2755716.48
Behavioral Services (Psychotherapy and Counseling)	Hour	2232	23.00	53.68	2755716.48	
Emergency Home Response Services (EHRS) Total:						2820.00
Emergency Home Response Services (EHRS)	Per Month	10	9.40	30.00	2820.00	
Home Accessibility Modifications Total:						1089885.66
Home Accessibility Modifications	Per Item	123	1.90	4663.61	1089885.66	
Non-Medical Transportation Total:						146281.84
Non-Medical Transportation	Per Item	214	46.00	14.86	146281.84	
Personal Support Total:						217239472.32
Personal Support	Hour	10426	1046.00	19.92	217239472.32	
Remote Support Total:						210000.00
Remote Support	Monthly	70	12.00	250.00	210000.00	
Skilled Nursing Total:						24327.60
Skilled Nursing	Hour	19	27.50	46.56	24327.60	
Supported Employment - Individual Employment Support Total:						10734738.54

GRAND TOTAL:	1883235902.39
Total Estimated Unduplicated Participants:	27766
Factor D (Divide total by number of participants):	67825.25
Average Length of Stay on the Waiver:	343

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Individual Employment Support	hour	1231	202.00	43.17	10734738.54	
Supported Employment – Small Group Supports Total:						1990509.12
Supported Employment – Small Group Supports	Hour	557	287.50	12.43	1990509.12	
Temporary Assistance Total:						579494.14
Temporary Assistance	Hour	109	241.00	22.06	579494.14	
Training and Counseling Services for Unpaid Caregivers Total:						1336.08
Training and Counseling Services for Unpaid Caregivers	Hourly	10	3.80	35.16	1336.08	
Vehicle Modification Total:						540000.00
Vehicle Modification	Per item	36	1.00	15000.00	540000.00	

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Average Length of Stay on the Waiver:	343