DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

June 27, 2022

Theresa Eagleson, Director
Division of Medical Programs
Illinois Department of Healthcare and Family Services
201 South Grand Avenue
Springfield, IL 62763-0002

RE: IL-22-0021 New §1915(i) Home and Community-Based Services (HCBS) State Plan Benefit/IL-02.R01 Special Needs Children (SNC) 1915(b) Waiver Renewal

Dear Ms. Eagleson:

The Centers for Medicare & Medicaid Services (CMS) is approving the state's request to amend its state plan to add a new 1915(i) home and community-based services (HCBS) benefit, transmittal number 22-0021. As part of this SPA, Illinois revised its 3.1-F pages, which authorizes managed care under 1932(a) to include the new 1915(i) program. The effective date for this 1915(i) benefit is July 1, 2022. Enclosed is a copy of the approved state plan amendment (SPA).

Since the state has elected to target the population who can receive §1915(i) State Plan HCBS, CMS approves this SPA for a five-year period expiring June 30, 2027, in accordance with §1915(i)(7) of the Social Security Act. To renew the §1915(i) State Plan HCBS benefit for an additional five-year period, the state must submit a renewal application to CMS at least 180 days prior to the end of the approval period. CMS approval of a renewal request is contingent upon state adherence to federal requirements and the state meeting its objectives with respect to quality improvement and beneficiary outcomes.

Per 42 CFR §441.745(a)(i), the state will annually provide CMS with the projected number of individuals to be enrolled in the benefit and the actual number of unduplicated individuals enrolled in the §1915(i) State Plan HCBS in the previous year. Additionally, at least 21 months prior to the end of the five-year approval period, the state must submit evidence of the state's quality monitoring in accordance with the Quality Improvement Strategy in their approved state plan amendment. The evidence must include data analysis, findings, remediation, and describe any system improvement for each of the §1915(i) requirements.

CMS reminds the state that the state must have an approved spending plan in order to use the money realized from section 9817 of the ARP. Approval of this action does not constitute approval of the state's spending plan.

It is important to note that CMS approval of this new 1915(i) HCBS state plan benefit solely addresses the state's compliance with the applicable Medicaid authorities. CMS approval does not address the state's independent and separate obligations under federal laws including, but not limited to, the Americans with Disabilities Act, § 504 of the Rehabilitation Act, or the Supreme Court's Olmstead decision. Guidance from the Department of Justice concerning compliance with the Americans with Disabilities Act and the Olmstead decision is available at http://www.ada.gov/olmstead/q&a_olmstead.htm.

Concurrently, the CMS is approving Illinois' request to renew the 1915(b) waiver, CMS Control Number IL-02.R01, titled Special Needs Children (SNC) program. This waiver allows Illinois to extend the mandatory managed care program, HealthChoice Illinois, to children with special needs under the SNC program. This 1915(b) waiver is authorized under sections 1915(b)(1) and 1915(b)(4) of the Social Security Act (the Act) and provides a waiver of the following sections of Title XIX:

- Section 1902(a)(10)(B) Comparability
- Section 1902(a)(23) Freedom of Choice.

Our decision is based on the evidence submitted to CMS demonstrating that the state's proposal is consistent with the purposes of the Medicaid program, will meet all of the statutory and regulatory requirements for assuring beneficiaries' access to and quality of services, and will be a cost-effective means of providing services to enrollees under this waiver.

This 1915(b) waiver renewal is approved for a two-year period effective July 1, 2022 through June 30, 2024. The state may request a renewal of this authority by providing evidence and documentation of satisfactory performance and oversight. Illinois' request that this authority be renewed should be submitted to CMS no later than April 1, 2024. Illinois will be responsible for documenting the applicable cost-effectiveness and quality in subsequent renewal requests for this authority.

On a quarterly basis, the state is required to submit to CMS the previous quarter's member months by approved MEG on the attached "1915(b) Worksheet for State Reporting of Member Months." The report is due 30 days after the end of each quarter and should be emailed to MCOGDMCOActions@cms.hhs.gov. The State should also conduct its own quarterly calculations using Tab D6 of the approved 1915(b) Waiver Cost Effectiveness Worksheets and request an amendment to the waiver should the State discover the waiver's actual costs are exceeding projections. Additionally, the State must submit a waiver amendment to reflect any major changes impacting the program, including changes in waivers/statutory authority needed, type/number of delivery systems, geographic areas, populations, services, quality/access, monitoring plan.

The state must arrange for an independent assessment (IA) of their 1915(b) waiver program and submit the findings when renewing the section 1915(b) waiver program. The IA should be submitted with the waiver renewal request ninety (90) days before the expiration of the approved waiver program.

We appreciate the cooperation your staff provided during the review of these submissions. If you have any questions concerning the 1915(i) SPA, please contact me at (410) 786-7561. You may also contact Michelle Taylor at Michelle.Taylor@cms.hhs.gov or (667) 290-8720. For questions related to the 1915(b) waiver, please contact Maria Chickering at (312) 886-0326 or via email at maria.chickering@cms.hhs.gov.

Sincerely,

George P. Failla, Jr., Director
Division of HCBS Operations and Oversight

Bill Brooks, Director
Division of Managed Care Operations

Enclosure: 1915(b) Worksheet for State Reporting of Member Months

cc:
Lynell Sanderson, CMS
Maria Chickering, CMS
Debi Benson, CMS
Deanna Clark, CMS
Kathryn Poisal, CMS
Courtenay Savage, CMS
Cynthia Nanes, CMS
Mara Siler-Price, CMS
Kelly Cunningham, HFS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 2 2 — 0 0 2 1

2. STATE: IL

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 441.710

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 12,500,000
b. FFY 2023 $ 50,000,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-I, Pages 1-52 NEW
Attachment 4.19-B, Pages 73-75 NEW
Attachment 3.1 F, Page 19

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-F, Page 19

9. SUBJECT OF AMENDMENT

1915(i) - Children's Mental Health Home and Community Based Services

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME: Theresa Eagleson

13. TITLE: Director of Healthcare and Family Services

14. DATE SUBMITTED: 6/9/2022

15. RETURN TO
Department of Healthcare and Family Services
Bureau of Program and Policy Coordination
Attn: Mary Doran
201 South Grand Avenue East
Springfield, IL 62763-0001

FOR CMS USE ONLY

16. DATE RECEIVED: 6/9/2022

17. DATE APPROVED: June 27, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL: July, 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL: Digitally signed by George P. Failla Jr -S Date: 2022.06.27 19:13:44 -04'00'

20. TYPED NAME OF APPROVING OFFICIAL: George P. Failla, Jr.

21. TITLE OF APPROVING OFFICIAL: Director, Division of HCBS Operations and Oversight

22. REMARKS

Pen & Ink change made to box 7 &8

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

Administration and Operation

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

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

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

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

***Select one*:**

○	**Not applicable**	
●	**Applicable**	
	Check the applicable authority or authorities:	
	☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
	☒	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*
		Special Needs Children (SNC) Waiver. The SNC Waiver has been previously approved by CMS. A renewal of the SNC Waiver has been submitted to CMS and is inclusive of the 1915(i) covered services.

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

☒	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☒	§1915(b)(4) (selective contracting/limit number of providers)

☒ **A program operated under §1932(a) of the Act.**
Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

The State Plan benefit covers the State's Managed Care program. The SPA has been previously approved by CMS and will be amended to include the additional 1915(i) covered services following CMS approval of the 1915(i) SPA.

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

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

◉ The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:

◉	The Medical Assistance Unit *(name of unit)*:	Division of Medical Programs
○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
	(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	

○ The State plan HCBS benefit is operated by *(name of agency)*

a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.

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

☒ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

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

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

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

Healthcare and Family Services (HFS), as Illinois' single state Medicaid agency, retains full authority and responsibility for the operation of the 1915(i) benefit through direct administration and oversight of contracted entities and enrolled service providers.

Delegation of Functions. All functions not performed directly by HFS shall be delegated in writing. HFS shall directly supervise the operations and performance of all contracted entities, including the review and approval of effective policies and procedures established by such entities. No delegated entity performing any of the 1915(i) benefit operations may substitute its own judgment for that of HFS with respect to the application of rules, regulation, policies, or procedures.

Function 3 - Review of participant service plans.

CCSOs shall review participant service plans. HFS will provide oversight and monitoring of CCSO performance in the development of participant service plans in collaboration with its UP and the MCOs

Function 4 - Prior authorization of State plan HCBS.

Prior authorization of Respite services shall be completed by the participant's MCO. For those participants in fee-for-service, prior authorization of Respite services shall be provided by the UP. The UP shall complete prior authorization of Therapeutic Support and Individuals Support services for all participants, regardless of their enrollment in managed care or the fee-for-service delivery system.

Function 5 - Utilization management.

Utilization management of Respite services shall be completed by the participant's MCO. For those participants in fee-for-service, Utilization Management of Respite services shall be provided by the UP. The UP shall conduct utilization management of Therapeutic Support and Individuals Support services for all participants, regardless of their enrollment in managed care or the fee-for-service delivery system.

Function 7 - Execution of Medicaid provider agreement.

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

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

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

Function 10 - Quality assurance and quality improvement activities.

HFS is responsible for the identification and establishment of quality assurance and quality improvement metrics and activities. The quality assurance and quality improvement metrics and activities are outlined in the Quality Improvement Strategy (QIS) in this SPA. MCOs (for individuals enrolled in managed care) and the UP (for fee-for-service) will support HFS in the collection of data that

will be used to monitor quality assurance metrics. HFS will analyze and report on the quality assurance and quality improvement data provided by the MCOs and the UP. HFS will identify trends and determine systemic changes needed to strengthen the QIS in this SPA based upon this analysis.

HFS will perform regular monitoring of MCO compliance with operational requirements of the 1915(i) delegated functions. HFS will require MCOs to include specific metrics related to 1915(i) delegated functions in their quarterly and annual reports to HFS. HFS will conduct ongoing technical assistance and operational meetings specific to the 1915(i) benefit with all MCOs to ensure operations are being conducted consistent with the benefit design and HFS expectations.

Finally, HFS will engage its UP to provide additional quality oversight by conducting clinical reviews and quality monitoring of the participant assessments/re-assessments and service plans for 1915(i) beneficiaries. The UP will provide data to HFS from these quality oversight activities. HFS will analyze this data to identify trends and determine systemic changes needed to strengthen the quality of participant assessments/re-assessments and service plans.

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

5. ☒ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:
   - related by blood or marriage to the individual, or any paid caregiver of the individual
   - financially responsible for the individual
   - empowered to make financial or health-related decisions on behalf of the individual
   - providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

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

Based upon the geographic and population challenges faced by rural Illinois, it is expected that there will be geographic areas where a single entity may be the only entity willing to meet the qualifications to provide all the 1915(i) benefit services. In this situation, some individuals may receive an assessment and service plan developed by the same provider who is also responsible for the delivery of services under the 1915(i) benefit. 82 of Illinois' 102 counties are identified by HRSA as having a shortage of mental health providers. Providers delivering services under the 1915(i) benefit in one of the 20 Illinois counties not identified by HRSA as having a shortage of mental health providers will be subject to and required to comply with the conflict of interest standards. In those 20 counties, CCSOs will be the entities responsible for maintaining the assessment and treatment plan for 1915(i) participants, with updates and information included based on the consensus of the Child and Family Team (CFT). CCSOs will not be permitted to be providers of any other 1915(i) benefit service in those 20 counties.

It is anticipated that these 82 counties with a shortage of mental health providers (listed below) may only have a single entity willing and qualified to provide all 1915(i) benefits.

Counties Designated as HPSA – Mental Health

Christian, Macoupin, Montgomery, Clark, Edgar, Iroquois, Vermilion, Bond, Madison, Fulton, McDonough, Alexander, Hardin, Jackson, Johnson, Massac, Perry, Pope, Pulaski, Randolph, Union, Coles, Cumberland, Douglas, Shelby, Adams, Brown, Cass, Hancock, Pike, Schuyler, Calhoun, Greene, Jersey, Morgan, Scott, De Witt, Macon, Moultrie, Piatt, Clay, Clinton, Crawford, Edwards, Effingham, Fayette, Jasper, Lawrence, Marion, Richland, Wabash, Wayne, Franklin, Gallatin, Hamilton, Jefferson, Saline, White, Williamson, Ford, Jo Daviess, Stephenson, LaSalle, Livingston, McLean, Bureau, Marshall, Putnam, Stark, Logan, Mason,

Menard, Monroe, Washington, Carroll, Lee, Ogle, Whiteside, Henderson, Henry, Knox, and Warren Counties.

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

1. An eligible individual and family's choice to participate in services is the first protection against conflict of interest. The eligible individual and/or their caregiver(s), when clinically appropriate, has complete autonomy to elect to participate in services under the 1915(i) benefit.
2. Upon determining that an individual is eligible for the 1915(i) benefit, the individual and/or their caregiver(s), when clinically appropriate, shall be provided a copy of HFS' Individual Rights for Participation Under Illinois' 1915(i) Benefit, to be furnished by HFS or its agent(s). The Individual Rights for Participation Under Illinois' 1915(i) Benefit will include information on the dispute resolution process, which include:
   a) The ability to contact their Care Coordinator, or the Care Coordinator's supervisor, if the participant has any problems/concerns. HFS will require CCSOs to establish an internal grievance process for tracking and resolving participant complaints.
   b) If the participant is uncomfortable reporting any problems/concerns to their Care Coordinator, they may file a grievance with their Managed Care Organization, the HFS Division of Medical Programs, or the state's designated Protection & Advocacy agency.
   c) The ability to access the state's appeals and fair hearings system in accordance with 42 CFR 431 Subpart E.
3. The individual's CCSO shall engage the individual and their caregiver, when clinically appropriate, secure all necessary consents for participation, and complete all required enrollment documentation. The enrollment documentation shall include the HFS 1915(i) Benefit Provider Selection Form, a listing of all providers in the service areas that offer 1915(i) benefit services, except Care Coordination and Support, for which the individual is eligible.
4. The individual and/or their caregiver, when clinically appropriate, will choose their provider(s) of service from the HFS 1915(i) Benefit Provider Selection Form with the understanding that their selection can be changed at any time, upon their request.
5. For providers that are the only available entity willing and qualified to provide all 1915(i) benefit services in a geographic area, HFS will require the entity have sufficient organizational separations and independence between operations (management structures, standard operating procedures, and separation of job functions) to prevent any possible conflict of interest. Specifically, the provider will be required to administratively separate the function of assessment and person-centered service planning from direct service provision functions.
6. HFS will prohibit the same professional within a provider agency from conducting both the assessment and person-centered service plan and providing state plan HCBS other than CCS to the same participant. Providers that provide both assessment and person-

centered service planning plan of care development, as well as 1915(i) HCBS must document the use of different professionals.

7. HFS will require all providers of 1915(i) Benefit Services to have a written conflict of interest policy detailing, at a minimum, the independence of persons performing evaluations, and service plans by attesting that these persons are not:
   a. Related by blood or marriage to the individual, or any paid caregiver of the individual;
   b. Financially responsible for the individual; or
   c. Empowered to make financial or health-related decisions on behalf of the individual.
8. To further prevent conflict of interest, HFS shall utilize quality of care monitoring activities to ensure compliance with the conflict of interest standards and processes described herein and fidelity to service delivery practices, including individual choice, person-centered processes for the development of the service plan, individual selection of service providers and preference for service delivery. HFS will ensure that assessments completed for 1915(i) participants are conducted with strong interrater reliability by performing desk audits of completed assessments. Random statistical sampling as well as trend analyses that identify outliers at the provider level will be utilized to inform the selection of assessments and providers for auditing.

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

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

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

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	7/01/2022	06/30/23	10,000
Year 2			
Year 3			
Year 4			
Year 5			

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

Financial Eligibility

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

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

☒ The State does not provide State plan HCBS to the medically needy.

☐ The State provides State plan HCBS to the medically needy. (*Select one*):

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

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

◉	Directly by the Medicaid agency

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

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

State employees making eligibility review decisions on applications submitted requesting 1915(i) eligibility must meet the following qualifications:

1) Bachelor's degree or equivalent experience;
2) Certified in the IM+CANS at the Supervisor level; and,
3) Trained in understanding and applying the IM+CANS decision support criteria.

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

HFS will provide oversight and monitoring of CBH and CCSO performance in the completion of service mental health assessments and re-assessments.

The initial evaluation process is as follows:

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

The re-evaluation process is as follows:

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

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

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

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

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

The Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) is used by the State to assist in assessing a youth and caregiver's strengths and needs but is not a diagnostic tool. The assessment tool and corresponding reference guide can be reviewed at: https://www2.illinois.gov/hfs/MedicalProviders/behavioral/CommunityMentalHealthCenter/Pages/IATP.aspx.

Patterns of IM+CANS ratings have been used to develop a Behavioral Health Decision Support Model. The Behavioral Health Decision Support Model is applied to a youth's IM+CANS assessment ratings over multiple life domains and results in a recommendation for one of the following four levels of need for community-based behavioral health services:

Level 4 – Standard Outpatient Services
Level 3 – Intensive Outpatient Services with Case Management
Level 2 – Intensive Home and Community-Based Services with Intensive Care Coordination
Level 1 – Intensive Home and Community-Based Services with High Fidelity Wraparound

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*Level 0 – Acute Psychiatric Hospitalization

Level 0, an institutional level of care, does not currently utilize the IM+CANS to assess whether an individual has met needs-based criteria. However, the needs-based criteria for Level 0 is more stringent than Levels 1-4.

The IM+CANS needs-based items utilized in the Behavioral Health Decision Support Model are rated using a '0' to '3' scale where:

0 = no evidence of a need; no need for action or support;
1 = monitoring of a need; preventive actions may be recommended;
2 = need is interfering with the individual's ability to function in at least one life domain and requires action; and,
3 = need is dangerous or disabling and is preventing the individual from functioning in multiple life domains and requires immediate action.

These ratings identify the youth's requirements for support based on an individualized assessment of need but are not diagnostically based. Nothing in the Behavioral Health Decision Support Model considers the youth's diagnosis in determining the recommended level of need for community-based behavioral health services.

Needs-Based Criteria:
Individuals must meet all the following needs-based criteria:

1) Demonstrate a need for assistance in at least one area of major life activity (i.e. decision-making, judgement, activities of daily living, preparing physically and/or emotionally for school including getting to school, developing/maintaining social relationships, maintaining family relationships, maintaining behavior in living situation, maintaining behavior when unsupervised, navigating within the community, effective communication skills) due to a functional need.

2) The following risk factors must be present in addition to meeting the needs-based criteria under criteria #1:
   - Minimally be recommended for Level 2 on the Behavioral Health Decision Support Model. A youth meets Level 2 on the Behavioral Health Decision Support Model when the ratings from the youth's IM+CANS demonstrates the following: (1) significant interference in the youth's ability to function in one or more life domains; (2) little or no participation in school, friendship groups, community life, and/or family life; and, (3) little or no ability to self-regulate, leading to interpersonal conflict within the home, school, and/or community setting; and,
   - Traditional outpatient services have been demonstrated as not adequate to support the youth's functional needs; and,
   - The youth demonstrates at least one of the following risk factors:
     - Be at risk of out-of-home treatment including psychiatric hospitalization or residential treatment; or,
     - Be at risk of manipulation or exploitation by others; or,
     - Demonstrate non-suicidal self-injurious behaviors that do not require immediate medical treatment; or,
     - The youth's caregiver demonstrates significant needs that impact their ability to successfully manage the youth's behaviors and that results in a negative impact on the youth's ability to function at home, at school, and/or in the community.

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

State plan HCBS needs-based eligibility criteria	NF (& NF LOC** waivers)	ICF/IID (& ICF/IID LOC waivers)	Applicable Hospital* (& Hospital LOC waivers)
The Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS) is used by the State to assist in assessing a youth and caregiver's strengths and needs but is not a diagnostic tool. The assessment tool and corresponding reference guide can be reviewed at: https://www2.illinois.gov/hfs/	**Persons with Disabilities:** • Medical determination of a diagnosed, severe disability, which is expected to last for 12 months or for the duration of life.	**Support Waiver for Children and Young Adults with Developmental Disabilities:** • Assessed as eligible for an institutional level of care for persons	**Medically Fragile, Technology Dependent Children Administrative Agency** • Requires level of care appropriate to a hospital or skilled nursing facility • Meets the minimum score on the Illinois

<table>
<tr>
<td>MedicalProviders/behavioral/CommunityMentalHealthCenter/Pages/IATP.aspx.

Patterns of IM+CANS ratings have been used to develop a Behavioral Health Decision Support Model. The Behavioral Health Decision Support Model is applied to a youth's IM+CANS assessment ratings over multiple life domains and results in a recommendation for one of the following four levels of need for community-based behavioral health services:

Level 4 – Standard Outpatient Services
Level 3 – Intensive Outpatient Services with Case Management
Level 2 – Intensive Home and Community-Based Services with Intensive Care Coordination
Level 1 – Intensive Home and Community-Based Services with High Fidelity Wraparound
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*Level 0 – Acute Psychiatric Hospitalization

Level 0, an institutional level of care, does not currently utilize the IM+CANS to assess whether an individual has met needs-based criteria. However, the needs-based criteria for Level 0 is more stringent than Levels 1-4.

The IM+CANS needs-based items utilized in the Behavioral Health Decision Support Model are rated using a '0' to '3' scale where:

0 = no evidence of a need; no need for action or support;</td>
<td>• Be at risk of nursing facility placement as measured by the Determination of Need (DON) assessment.

Persons with Brain Injury (BI)
• Have functional limitations directly resulting from an acquired brain injury as documented by a physician or neurologist.
• Be at risk of nursing facility placement as measured by the Determination of Need (DON) assessment.

Persons who are Elderly
• Be at risk of nursing facility placement as measured by the Determination of Need (DON) assessment.

Persons with HIV or AIDS
• Medical determination of HIV or AIDS with severe functional limitations, which is expected to last for at least 12 months or for the duration of life
• Be at risk of nursing facility placement as measured by the Determination of</td>
<td>with intellectual disabilities or conditions similar to intellectual disabilities.

Residential Services for Children and Young Adults with Developmental Disabilities
• Children and young adults with developmental disabilities who are at risk of placement in an Intermediate Care Facility for persons with Developmental Disabilities (ICF/DD).
• Assessed as eligible for an institutional level of care for persons with intellectual disabilities or conditions similar to intellectual disabilities.

Adults with Developmental Disabilities
• Assessed as eligible for an institutional level of care for persons with intellectual disabilities or conditions similar</td>
<td>approved Level of Care (LOC) tool

Hospital
• Meets the Interqual criteria for acute hospital care based on the primary diagnosis and clinical presentation of the individual.
• Displays an imminent risk of harm to self or others requiring 24/7 monitored psychiatric care.

Long Term Acute Care (LTAC) Hospital
• Meets the Interqual criteria for long-term acute hospital care based on the primary diagnosis and clinical presentation of the individual.
• Condition requires extended 24/7 medically monitored care.</td>
</tr>
</table>

1 = monitoring of a need; preventive actions may be recommended; 2 = need is interfering with the individual's ability to function in at least one life domain and requires action; and, 3 = need is dangerous or disabling and is preventing the individual from functioning in multiple life domains and requires immediate action. These ratings identify the youth's requirements for support based on an individualized assessment of need but are not diagnostically based. Nothing in the Behavioral Health Decision Support Model considers the youth's diagnosis in determining the recommended level of need for community-based behavioral health services. **Needs-Based Criteria:** Individuals must meet all the following needs-based criteria: 1) Demonstrate a need for assistance in at least one area of major life activity (i.e. decision-making, judgement, activities of daily living, preparing physically and/or emotionally for school including getting to school, developing/maintaining social relationships, maintaining family relationships, maintaining behavior in living situation, maintaining behavior when unsupervised, navigating within the community, effective communication skills) due to a functional need. 2) The following risk factors must be present in addition	Need (DON) assessment. **Supportive Living Program** • Found to be in need of nursing facility level of care and Supportive Living Program is appropriate to meet the person's needs.	to intellectual disabilities.	

to meeting the needs-based criteria under criteria #1: • Minimally be recommended for Level 2 on the Behavioral Health Decision Support Model. A youth meets Level 2 on the Behavioral Health Decision Support Model when the ratings from the youth's IM+CANS demonstrates the following: (1) significant interference in the youth's ability to function in one or more life domains; (2) little or no participation in school, friendship groups, community life, and/or family life; and, (3) little or no ability to self-regulate, leading to interpersonal conflict within the home, school, and/or community setting; and, • Traditional outpatient services have been demonstrated as not adequate to support the youth's functional needs; and, • The youth demonstrates at least one of the following risk factors: o Be at risk of out-of-home treatment including psychiatric hospitalization or residential treatment; or, o Be at risk of manipulation or exploitation by others; or, o Demonstrate non-suicidal self-injurious behaviors that do not require			

immediate medical treatment; or, o The youth's caregiver demonstrates significant needs that impact their ability to successfully manage the youth's behaviors and that results in a negative impact on the youth's ability to function at home, at school, and/or in the community.			

*Long Term Care/Chronic Care Hospital

**LOC= level of care

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

Services will be provided to children meeting the following targeted eligibility criteria. The individual: 1. Is under 21 years of age; and 2. Demonstrates a Serious Emotional Disturbance (SED), as defined in 89 ILAC 139.115(e)(1), or has been diagnosed with a Serious and Persistent Mental Illness, based on the most current version of the Diagnostic and Statistical Manual (DSM). The established diagnosis or need cannot be the result of an acute episode.

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

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

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

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i)

service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

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

Home and Community-Based Settings

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

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

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

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

1) a home or apartment with parents, family, or legal guardian or living independently, that is owned or leased by the individual or their parent or legal guardian. These are not homes or apartments that are owned, leased or controlled by a provider of any health-related treatment or support services; or

2) a licensed foster care home. These settings are the private homes of foster parents who have been determined by the Department of Children and Family Services (DCFS), the State's child welfare agency, to meet a number of standard environmental and physical space dimensions of the home which are geared toward the individual needs of the children who live there. These are not group homes with staff providing services. Foster families are not paid for providing HCBS services to individuals.

Upon enrollment into the 1915(i) benefit, HFS shall verify that the individual's residential address meets the HCBS setting requirements.

Any type of institutional or institution-like residence as defined by federal regulations will be considered a non-compliant HCBS setting.

Throughout the course of 1915(i) benefit participation, the individual's CCSO will continue to monitor the home and community-based settings. Participants shall be required to contact the CCSO at any time they relocate. The CCSO will be required to confirm the participant's residence no less frequently than on a quarterly basis. If, during the eligibility period the participant is found to be in an institutional, institution-like, or otherwise non-compliant setting, the CCSO shall notify HFS of the change of status. HFS will be notified if the participant will be out of the identified setting for more than 14 days.

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

1. A site visit will be conducted by the individual's CCSO;
2. If the setting is found to be in compliance, or if immediate remediation of the non-compliance can be completed, the CCSO will report to HFS that no further action is required.
3. If at the site visit the CCSO finds that the setting is out of compliance and immediate remediation is not possible, the CCSO will report these findings to HFS.
4. HFS will notify the UP that a follow-up site visit must be conducted by the UP and findings reported directly to HFS.
5. If it is found that participant is residing in an institution or institution-like setting that cannot implement remediation actions such as a residential, group home or other congregate setting, the UP will report this directly to HFS and the participant will either be moved to a setting that is in compliance or the participant will be disenrolled from the 1915(i) into other appropriate services.
6. If remediation of the setting is warranted and possible, a remediation plan will be developed, and the provider given a period of 30 days to implement remediation efforts.
7. If it is found the participant is residing in an institution or institution-like setting that cannot implement remediation actions, such as a sub-acute level of care or residential treatment center that cannot implement remediation to come into compliance (i.e. the participant has escalated to require a medically necessary level of care that restricts the individual's choice to receive

services outside of the setting for the participant's own safety or the safety of others or the community), the UP will report this directly to HFS and the participant will either be moved within 90 days to a setting that is in compliance or the participant will stop receiving services under the 1915(i) and be transitioned into other appropriate services.

8. The provider will submit proof of its remediation efforts to HFS at the end of the 30 day period. HFS will review the outcome of the remediation efforts to determine if the setting: fully complies, will fully comply with additional changes, or does not and cannot meet community settings requirements.
9. If a decision is made that the setting fully complies, written correspondence will be provided to the CCSO and provider (site owner).
10. If a decision is made that the setting would comply with additional changes, written correspondence of the required changes will be provided to the provider (site owner). The provider will be given an additional 7 days to implement the necessary remediations and demonstrate proof of implementation to HFS. If the setting has not been remedied, a denial will be issued for that setting.
11. If a decision is made that the setting cannot be remedied, a denial will be issued for that setting.
12. The participant will either be moved within 90 days to a setting that is in compliance or the participant will stop receiving services under the 1915(i) and be transitioned into other appropriate services. The CCSO will assist in identifying a new setting and will work with the participant to ensure that they are transitioned to their new setting with appropriate services and supports in place. If the participant will be transitioned to other services, the CCSO will ensure that the transition to new services is completed within 90 days and that all required services and supports are identified and available to the participant prior to the transition.
13. If it is determined to be clinically inappropriate or potentially dangerous or disabling to relocate the participant to a compliant setting, HFS will ensure the participant has the necessary services and supports in place, disenroll the participant from the 1915(i) benefit, and inform the participant.

HFS will not reimburse HCBS for participants in denied or non-compliant settings pursuant to the 1915(i) authority.

Person-Centered Planning & Service Delivery

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

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

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

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

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

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

Mental Health Professionals (MHP)

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

Licensed Practitioners of the Healing Arts (LPHA)

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

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

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

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

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

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

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

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

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

d) Ensuring the person-centered plan is finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation in accordance with the 42 CFR §441.301.

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

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

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

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

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

Participants will receive Care Coordination and Support Services from HFS' selected provider. HFS, in collaboration with its MCOs, shall establish a five (5) year application cycle to identify entities meeting the terms of the 1915(i) benefit, inclusive of HFS' Conflict of Interest requirements as described in this application. Qualified providers shall be responsible for providing Care Coordination and Support Services for a specific geographical area defined by HFS, ensuring a statewide network of providers willing and qualified to deliver mental health service assessments, service re-assessments, and service planning. Individuals will be offered their choice of available providers for all other 1915(i) services consistent with the process described above.

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

All person-centered service plans shall be submitted by the individual's CCSO to HFS via the IATP Data Portal, making the plan subject to the approval of HFS. UP shall perform annual sampling of independent assessments and person-centered service plans to ensure adherence to federal HCBS rules and regulations. Findings of such sampling shall be reported to HFS for oversight and management of outcomes.

9. **Maintenance of Person-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

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

Services

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:	
Service Title:	Care Coordination and Support (CCS)
Service Definition (Scope):	

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

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

CCS services are provided by Care Coordination and Support Organizations (CCSO) that are organized around the Systems of Care philosophy of interagency collaboration, individualized

strengths-based care, cultural competence, child and family involvement, community-based services, and accountability. CCSO providers must be immediately available 24 hours a day, 7 days a week, each week of the year to prevent, respond to, de-escalate, and mitigate crisis situations.

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

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

CCS services are to be provided in a variety of modalities, locations, and times based upon the needs and preferences of the family.

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

The decision support criteria based on the child's IATP (described previously) will determine which intensity of care coordination the child will receive.

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

(Choose each that applies):

☒	Categorically needy *(specify limits):*

	The service is automatically authorized for any individual meeting the eligibility criteria for the 1915(i) with the intensity of the care coordination service based on the decision support criteria described previously. The services under the 1915(i) SPA 22-0021 are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization. It is anticipated, and expected, that children who are eligible for the 1915(i) benefit will be involved in multiple systems, waivers, and State Plan services, etc., and will receive continued specialized case management from each. For example, the participant involved in the 1915(i) benefit to address behavioral health needs may be in the foster care system and receiving Special Education services. Each of these components offer case management in their areas of expertise and serve an essential role in the individual's care. While the individual may have multiple case managers, the State will develop a process to prevent the duplication of Medicaid funded services and/or duplication of Medicaid payment and may not bill simultaneously for services furnished under any other Medicaid authority (e.g., Targeted Case Management). Services furnished through the 1915(i) benefit must not be duplicated by services funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.). To ensure duplication does not occur providers must coordinate efforts with the Department of Instruction and/ or local Vocational Rehabilitation Agency. Justification that services are not otherwise available to the individual through these agencies under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1400 et seq.) must be documented in the individual's record and kept on file. Additionally, individuals enrolled in CCS services are expected to receive CASPR services in lieu of Mobile Crisis Response (MCR) services, when presenting in crisis in their local community. By ensuring that CASPR services are provided in lieu of MCR, individuals receiving 1915(i) benefit services can ensure that changes in their level of care and immediate crisis needs are responded to by their treatment planning team, increasing service continuity and community stabilization. Moreover, assessment, such as crisis assessment, is one of many forms of case management service that are performed by the CCSO and its staff, in lieu of traditional case management services to ensure no duplication of service occurs with individuals who are eligible for 1915(i) benefit services.
☐	Medically needy *(specify limits)*:

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Care Coordination and Support Organizations	N/A	Providers must be certified as a Community Mental Health Center (59 IAC 132) or a Behavioral	Staff delivering CCS services must minimally: • Meet the qualification of an MHP as defined in 89 IAC 140.453; • Have 1 year of experience delivering behavioral health services;

		Health Clinic (89 IAC 140.499) and must maintain a separate Program Approval on their Medicaid enrollment as a provider of Crisis Services and Care Coordination and Support Services.	• Maintain annual certification in the IATP instrument; • Complete HFS' annual training on crisis services; and • Completed the HFS Wrapround or Intensive Care Coordinator certification process. Supervisors of staff delivering this service must maintain an average supervisor to staff ratio of 1:8 and must minimally: • Meet the qualifications of an QMHP as defined in 89 IAC 140.453; • Have 3 years of experience delivering behavioral health services; • Maintain annual certification in the IATP instrument; • Complete HFS' annual training on crisis services; and • Completed the HFS Wrapround or Intensive Care Coordination Supervisor certification process. Clinical Managers who provide oversight and clinical supervision to Care Coordination Supervisors must minimally: • Meet the qualifications of an LPHA as defined in 89 IAC 140.453; and • Maintain annual certification in the IATP instrument.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Care Coordination and Support Organizations	HFS in partnership with contracted MCOs.	HFS, in collaboration with its MCOs, shall establish a five (5) year application cycle to identify entities meeting the terms of the 1915(i) benefit, inclusive of HFS' Conflict of Interest requirements as described in this application. Selected providers shall be responsible for providing Care Coordination and Support Services for

		a specific geographical area defined by HFS, ensuring a statewide network of providers willing and qualified to deliver Independent Evaluation, Re-evaluation, and Service planning. HFS will provide annual monitoring of provider quality and adherence to Program Approval requirements.
Service Delivery Method. *(Check each that applies)*:		
☐ Participant-directed		☒ Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:	
Service Title:	**Family Peer Support**
Service Definition (Scope)*:*	
Family Peer Support is defined as a structured, strengths-based, individualized, medically necessary service provided to a parent, legal guardian, or primary caregiver of an individual qualifying for 1915(i) CMH HCBS as detailed above. Family Peer Support services are directed toward the well-being and benefit of the child. Family Peer Support is designed to enhance the caregiver's capacity to manage the individual's behavioral health needs through the development of skills, knowledge, and parenting techniques necessary to improve coping abilities and to address the individual's social-emotional health needs. Family Peer Supporters serve as advocates, mentors, and coaches for caregivers, providing support from the peer perspective. Family Peer Support consists of the following activities: caregiver skill development; assisting the family in self-advocacy; educating the caregiver on how to navigate systems of care and how to effectively share their concerns, needs, and vision for the future; emotional support to the caregiver; empowering caregivers to make informed decisions about their own family's care; systems navigation; assisting the family in engaging and developing its natural support system; and promoting effective family-driven practice. Family Peer Support must be recommended by an LPHA, in collaboration with the child and family team, and recorded on the Individual Plan of Care.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies)*:	
☒ Categorically needy *(specify limits)*:	

<table>
<tr><td></td><td colspan="3">The service is automatically authorized for any individual meeting the eligibility criteria for the 1915(i) CMH-HCBS and for whom an LPHA recommends Family Peer Support services on the service plan. The services under the 1915(i) SPA 22-0021 are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

Family Peer Support services are to be rendered consistent with frequency, duration, and scope recommended on the service plan. The services provided under Family Peer Support may not be duplicative of other Medicaid Rehabilitation Option or HCBS benefit services. Family Peer Support may be provided, and billed, for meeting with the family in-person, telephonically, or through video communications. Family Peer Support services may not be provided in a group setting. Family Peer Support may not be billed for telephonic communications with other providers or resources.</td></tr>
<tr><td>☐</td><td colspan="3">Medically needy (specify limits):</td></tr>
<tr><td></td><td colspan="3"></td></tr>
<tr><td colspan="4">Provider Qualifications (For each type of provider. Copy rows as needed):</td></tr>
<tr><td>Provider Type (Specify):</td><td>License (Specify):</td><td>Certification (Specify):</td><td>Other Standard (Specify):</td></tr>
<tr><td>Family Peer Support Providers</td><td>N/A</td><td>Providers must be certified as a Community Mental Health Center (59 IAC 132) or a Behavioral Health Clinic (89 IAC 140.499).</td><td>Staff delivering services must minimally:
• Meet the qualifications of a Rehabilitative Services Associate (RSA) as defined in 89 IAC 140.453;
• Have individual lived experience or experience as a caregiver of a child with special needs, preferably behavioral health needs;
• Have experience in navigating any of the child-serving systems;
• Have experience in supporting, educating and advocating for family members who are involved with the child-serving systems;
• Have access to a Qualified Mental Health Professional (QMHP) or LPHA as defined in 89 IAC 140.453 for clinical consultation;
• Complete the HFS Family Peer Support training process; and
• Actively participate in ongoing training and coaching by the state or its designee.</td></tr>
</table>

<table>
<tr><td colspan="3">Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):</td></tr>
<tr><td>Provider Type (Specify):</td><td>Entity Responsible for Verification (Specify):</td><td>Frequency of Verification (Specify):</td></tr>
</table>

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

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:	
Service Title:	**Intensive Home-Based Services**
Service Definition (Scope)*:*	
Intensive Home-Based Services (IHBS) are team-based, individualized, time-limited, focused services provided directly to children and their caregivers in home and community settings to: 1) improve child and family functioning; 2) improve the family's ability to provide effective support for the youth; and 3) promote healthy family functioning. IHBS include a series of evidence-informed interventions provided by the IHBS team, including functional assessments, observation, coaching, individualized interventions, and behavior management. Interventions are designed to enhance and improve the family's capacity to maintain the child within the home and community, and to prevent the child's admission to an inpatient hospital or other out-of-home treatment setting.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☒	Categorically needy *(specify limits):*
	Intensive Home-Based Services may be provided to any individual meeting the eligibility criteria for the 1915(i) CMH-HCBS and for whom an LPHA recommends IHBS on the service plan. The services under the 1915(i) SPA 22-0021 are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization. IHBS services are to be rendered consistent with frequency, duration, and scope recommended on the service plan. Intensive Home-Based Services must be provided by the team in the home or the community setting and may include a variety of modalities, including in-person, phone, and videoconference based upon the needs and preferences of the individual. Services are individual-based and family-based in their delivery. Intensive Home-Based Services may not be billed on the same day as Community Support, Assertive Community Treatment (ACT), or Therapy/Counseling to ensure there is no duplication of other services.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Intensive Home-Based Service Providers	N/A	Providers must be certified as a Community Mental Health Center (59 IAC 132) or a Behavioral Health Clinic (89 IAC 140.499).	IHBS interventions are delivered by team that minimally consists of a clinician and support worker who meet the following qualifications: IHBS Clinician – a QMHP or LPHA, as defined in 89 IAC 140.453, who has been certified as a Therapist in PracticeWise system guidelines, or another HFS approved evidence-based practice, and has completed HFS approved training in family therapy or other evidence-based practice approved by HFS. IHBS Support Worker - an MHP, as detailed in 89 ILAC Section 140.453, with a minimum of two years' experience working with children and families and with training in the PracticeWise system guidelines, or another HFS approved evidence-based practice, and has completed HFS-approved training in family therapy or other evidence-based practice approved by HFS. IHBS Support Workers must be under the clinical direction of the IHBS Clinician.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Intensive Home-Based Service Providers	HFS	At the time of enrollment and at least every three years

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:	
Service Title:	**Respite (Home or Community)**
Service Definition (Scope):	
Respite is a time-limited, supervised service that is individualized and provides families scheduled relief to help prevent stressful situations, including avoiding a crisis or escalation within the home. Services shall be provided in the home and in locations within the child's community with the intent of	

providing both child and caregiver supportive time apart to reduce stress and increase the likelihood of the child remaining safely at home and in the community. Respite services shall not be provided in a facility, and no federal financial participation shall be claimed for the cost of room and board for this service.

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

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

☒	Categorically needy *(specify limits):*
	The services under the 1915(i) SPA 22-0021 are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization. Respite Services shall not exceed seven (7) hours per event, 21 hours per month, or 200 hours annually without authorization. Additional hours of Respite services may be authorized when deemed medically necessary. This service must be planned, recommended by an LPHA, in conjunction with the CFT, and documented on the authorized service plan as a needed service. Respite Services may only be provided in-person; reimbursement for Respite shall not be available for services rendered telephonically, via videoconference or by members of the child's family. Group services shall not exceed a 3:1 child to staff ratio.
☐	Medically needy *(specify limits):*

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

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

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Respite Providers	HFS	At the time of enrollment and at least every three years

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

o	Participant-directed	☒	Provider managed

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

Service Title:	**Therapeutic Mentoring**

Service Definition (Scope):

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

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

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

(Choose each that applies):

☒	Categorically needy *(specify limits):*
	The service is automatically authorized for any individual meeting the eligibility criteria for the 1915(i) CMH-HCBS and for whom an LPHA, in collaboration with the CFT, recommends Therapeutic Mentoring services on the service plan. The services under the 1915(i) SPA 22-0021 are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization. Therapeutic Mentoring services are to be rendered consistent with frequency, duration, and scope recommended on the service plan. The services provided under Therapeutic Mentoring may not be duplicative of other Medicaid Rehabilitation Option or HCBS benefit services. Therapeutic Mentoring may be provided, and billed, for meeting with the family in-person, telephonically, or through video communications. Therapeutic Mentoring services may not be provided in a group setting.
☐	Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Therapeutic Mentoring Providers	N/A	Providers must be certified as a Community Mental Health Center (59 IAC	Staff delivering services must minimally: • Meet the qualifications of an RSA as defined in 89 IAC 140.453; • Have access to a Qualified Mental Health Professional (QMHP) or

		132) or a Behavioral Health Clinic (89 IAC 140.499).	LPHA as defined in 89 IAC 140.453 for clinical consultation; and • Complete the HFS Therapeutic Mentoring training process.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Therapeutic Mentoring Providers	HFS	At the time of enrollment and at least every three years

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

☐	Participant-directed	☒	Provider managed

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

Service Title:	**Therapeutic Support Services (TSS)**

Service Definition (Scope):

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

TSS include the following types of interventions:

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

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

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

(Choose each that applies):

☒	Categorically needy *(specify limits):*

	The services under the 1915(i) SPA 22-0021 are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization. Therapeutic Support Services shall not exceed $3000 per state fiscal year per child and are subject to Prior Authorization. The specific TSS interventions must be documented as a recommended service by the authorizing LPHA, in collaboration with the CFT, on the child's service plan. The services provided under TSS may not be duplicative of other Medicaid Rehabilitation Option or HCBS benefit services.
☐	Medically needy *(specify limits):*

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

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Therapeutic Support Service Providers	N/A	N/A	To provide a particular Therapeutic Support Service, an individual shall have: (a) A bachelor's or master's degree from an accredited college or university; and (b) demonstration of training or certification specific to the service being rendered. The child's CCSO will serve as the fiscal agent for this service, authorizing individual services and directly reimbursing qualified providers. The CCSO shall have written policies and procedures to ensure accountability, verify provider qualifications, and ensure that all Therapeutic Support Service are verifiable. The CCSO shall revise its policies as needed and communicate the changes in writing to all parties. The CCSO shall account for all funds used and shall comply with requirements established by HFS.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Therapeutic Support Service Providers	Fiscal agent (CCSO)	At the time a TSS is approved.

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

☐	Participant-directed	☒	Provider managed

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

<table>
<tr><td>Service Title:</td><td colspan="2">Individual Supports and Services (ISS)</td></tr>
<tr><td colspan="3">Service Definition (Scope):</td></tr>
<tr><td colspan="3">Individual Supports and Services are non-traditional activities, services and goods that provide therapeutic supports to children with significant behavioral health needs in support of the child's person-centered service plan and as an adjunct to traditional therapeutic services the child receives. ISS promote health, wellness and behavioral health stability through community and family stabilization. ISS may only be provided for the direct benefit of the child and may not be provided to family members or other collaterals involved with the child's care.

The specific ISS interventions must be documented as a recommended service by the authorizing LPHA, in collaboration with the CFT, on the child's service plan and must be directly tied to supporting the achievement of one or more goals on the child's service plan.

ISS include the following categories of activities, services and goods.
• Physical wellness activities and goods that promote a healthy lifestyle through physical activity (i.e. sports club fees or gym memberships; bicycles, scooters, roller skates and related safety equipment;) and nutrition education (i.e. cooking classes, non-credit nutrition courses);
• Special or therapeutic youth development programs offered by a community-based organization that serve individuals with disabilities who otherwise would not be able to successfully participate in traditional youth development programs. These programs focus on developing social skills through youth development opportunities that are supported by staff with specialized training;
• Strengths-developing activities (i.e. music lessons, art lessons, therapeutic summer camp);
• Sensory items ordered by an Occupational Therapist, Speech-Language Pathologist, Physical Therapist, or Licensed Practitioner of the Healing Arts as defined in 89 Ill. Adm. Code 140.453(b)(3); and
• Parent education and training.</td></tr>
<tr><td colspan="3">Additional needs-based criteria for receiving the service, if applicable (specify):</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.
(Choose each that applies):</td></tr>
<tr><td rowspan="2">☒</td><td colspan="2">Categorically needy (specify limits):</td></tr>
<tr><td colspan="2">The services under the 1915(i) SPA 22-0021 are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization. Individual Supports shall not exceed $1500 per state fiscal year and are subject to Prior Authorization. The specific ISS interventions must be documented as a recommended service by the authorizing LPHA, in collaboration with the CFT, on the child's service plan and must be directly tied to supporting the achievement of one or more goals on the child's service plan. The services provided under ISS may not be duplicative of other Medicaid Rehabilitation Option or 1915(i) benefit.</td></tr>
<tr><td rowspan="2">☐</td><td colspan="2">Medically needy (specify limits):</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="3">Provider Qualifications (For each type of provider. Copy rows as needed):</td></tr>
</table>

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Individual Support Service Providers	N/A	N/A	The child's CCSO will serve as the fiscal agent for this service, authorizing individual services and directly reimbursing qualified providers. The CCSO shall have written policies and procedures to ensure accountability, verify provider qualifications, and ensure that all Individual Support Services are verifiable. The CCSO shall revise its policies as needed and communicate the changes in writing to all parties. The CCSO shall account for all funds used and shall comply with requirements established by HFS.

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

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Individual Support Service Providers	Fiscal agent (CCSO)	At the time an ISS is approved.

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

☐	Participant-directed	☒	Provider managed

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

N/A

Participant-Direction of Services

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

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

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

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

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

N/A

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

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

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

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

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

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

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:
   - Specifies the State plan HCBS that the individual will be responsible for directing;
   - Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;

- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

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

N/A

8. Opportunities for Participant-Direction

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

●	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

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

Quality Improvement Strategy

Quality Measures

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

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

Requirement	1a) Service plans address assessed needs of 1915(i) participants
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of person-centered service plans that address assessed needs of 1915(i) participants, based upon the completed IATP and person-centered service plan. N = number of person-centered service plans that address assessed needs of the 1915(i) participants. D = Total number of person-centered service plans reviewed.
Discovery Activity *(source of data & sample size)*	Source of Data = Record review of 1915(i) participant person-centered service plans. Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.
Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	MCOs University Partner
Frequency	Annually
Remediation	
Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS MCOs If a Corrective Action Plan (CAP) is needed, it must be provided to HFS or the appropriate MCO within 15 business days. HFS or the MCO will respond within 15 business days. Remediation must be completed within 30 business days after the response from HFS or the MCO.
Frequency *(of Analysis and Aggregation)*	Annually.

Requirement	1b) Service plans are updated at least every 180 days.

Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of person-centered service plans reviewed and revised on or before the required 180-day review date. N = number of person-centered service plans reviewed and revised on or before the required 180-day review date. D = Total number of person-centered service plans reviewed.
	Discovery Activity *(source of data & sample size)*	Source of Data = Record review of 1915(i) participant person-centered service plans. Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	HFS MCOs
	Frequency	Quarterly.
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS MCOs If a Corrective Action Plan (CAP) is needed, it must be provided to HFS or the appropriate MCO within 15 business days. HFS or the MCO will respond within 15 business days. Remediation must be completed within 30 business days after the response from HFS or the MCO.
	Frequency *(of Analysis and Aggregation)*	Quarterly.

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

		number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	MCOs University Partner
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS MCOs If a Corrective Action Plan (CAP) is needed, it must be provided to HFS or the appropriate MCO within 15 business days. HFS or the MCO will respond within 15 business days. Remediation must be completed within 30 business days after the response from HFS or the MCO.
	Frequency *(of Analysis and Aggregation)*	Annually.

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

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

		number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	MCOs University Partner
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS MCOs If a Corrective Action Plan (CAP) is needed, it must be provided to HFS or the appropriate MCO within 15 business days. HFS or the MCO will respond within 15 business days. Remediation must be completed within 30 business days after the response from HFS or the MCO.
	Frequency *(of Analysis and Aggregation)*	Annually.

Requirement		2b) The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately.
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of participant eligibility reviews completed according to the process and instruments described in the State Plan Amendment. N = number of participant eligibility reviews completed according to the process and instruments described in the State Plan Amendment. D = Total number of participant eligibility reviews completed.
	Discovery Activity *(source of data & sample size)*	Source of Data = Record review of 1915(i) participants' IATP. Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	MCOs University Partner
	Frequency	Annually
Remediation		
	Remediation Responsibilities	HFS MCOs

	(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	If a Corrective Action Plan (CAP) is needed, it must be provided to HFS or the appropriate MCO within 15 business days. HFS or the MCO will respond within 15 business days. Remediation must be completed within 30 business days after the response from HFS or the MCO.
	Frequency *(of Analysis and Aggregation)*	Annually.

Requirement		2c) The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of participants whose eligibility was reviewed within 6 months of their previous eligibility review. N = number of 1915(i) participants whose eligibility was reviewed within 6 months of their previous eligibility review. D = Total number of 1915(i) participants whose 6-month eligibility review was required.
	Discovery Activity *(source of data & sample size)*	Source of Data = Record review of 1915(i) participants' IATP. Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of individual participants enrolled in the 1915(i) at the point in time the sample is drawn.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	HFS MCOs
	Frequency	Quarterly.
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS MCOs If a Corrective Action Plan (CAP) is needed, it must be provided to HFS or the appropriate MCO within 15 business days. HFS or the MCO will respond within 15 business days. Remediation must be completed within 30 business days after the response from HFS or the MCO.
	Frequency *(of Analysis and Aggregation)*	Quarterly.

Requirement	2d) The assessment tool for individuals seeking 1915(i) eligibility is completed with strong reliability (e.g. an interrater reliability score of 0.7 or higher).
Discovery	

	Discovery Evidence *(Performance Measure)*	The number and percent of IATPs upon which an eligibility review is completed within the current month under review that are completed with strong reliability (e.g. an interrater reliability score of 0.7 or higher). N = number of IATPs upon which an eligibility review is completed within the current month that are completed with strong reliability (e.g. an interrater reliability score of 0.7 or higher). D = Total number of IATPs upon which an eligibility review is completed within the current month.
	Discovery Activity *(source of data & sample size)*	Source of Data = Record review of individual's IATP. Sample Size = A representative sample of the total population with a 95% confidence level and +/- 5% margin of error. Total population equals the number of individuals seeking 1915(i) eligibility within the month the sample is drawn.
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	University Partner
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS If a Corrective Action Plan (CAP) is needed, it must be provided to HFS within 15 business days. HFS will respond within 15 business days. Remediation must be completed within 30 business days after the response from HFS.
	Frequency *(of Analysis and Aggregation)*	Annually.

3. **Providers meet required qualifications.**

Requirement		3a) Providers meet required qualifications (initially)
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of service providers who initially met required provider qualifications prior to furnishing 1915(i) services. N = number of service providers who met required qualifications prior to furnishing 1915(i) services. D = Total number of 1915(i) authorized service providers.
	Discovery Activity *(source of data & sample size)*	Source of Data = HFS IMPACT system 100% review.

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

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

	(of Analysis and Aggregation)	

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

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

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

Requirement		5a) The SMA retains authority and responsibility for program operations and oversight.
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of quarterly meetings between HFS and its contracted entities (MCOs, UP) where the contracted entity's performance on delegated functions was reviewed as specified in the SPA. N = number of quarterly meetings between HFS and its contracted entities where the contracted entity's performance on delegated functions was reviewed as specified in the SPA. D = Total number of quarterly meetings between HFS and its contracted entities.
	Discovery Activity *(source of data & sample size)*	Source of Data = Meeting agendas and minutes 100% review
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	HFS
	Frequency	Quarterly
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS If a Corrective Action Plan (CAP) is needed, it must be provided to HFS within 15 business days. HFS will respond within 15 business days. Remediation must be completed within 30 business days after the response from HFS.
	Frequency *(of Analysis and Aggregation)*	Quarterly

Requirement		5b) The SMA retains authority and responsibility for program operations and oversight.
Discovery		
	Discovery Evidence *(Performance Measure)*	The number and percent of annual performance reports from contracted entities (MCOs, UP) reviewed to ensure administrative oversight. N = number of annual performance reports from contracted entities submitted timely. D = Total number of annual performance reports due.

	Discovery Activity *(source of data & sample size)*	Source of Data = Contracted entities' Annual Reports 100% review
	Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	HFS
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS HFS will require completion and submission of overdue reports. If a Corrective Action Plan (CAP) is needed, it must be provided to HFS within 15 business days. HFS will respond within 15 business days. Remediation must be completed within 30 business days after the response from HFS.
	Frequency *(of Analysis and Aggregation)*	Annually.

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

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

	Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS HFS will require MCOs or providers to void any inappropriate claims for 1915(i) services that were paid. Remediation must be completed within 30 business days.
	Frequency *(of Analysis and Aggregation)*	Annually.

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

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

Requirement	7a) The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of incidents reported within required timeframes. N = number of incident reports submitted within required timeframes. D = Total number of incident reports submitted.
Discovery Activity *(source of data & sample size)*	Source of Data = record review of submitted incident reports 100% review.
Monitoring Responsibilities *(agency or entity that conducts discovery activities)*	HFS MCOs
Frequency	Continuous and ongoing
Remediation	
Remediation Responsibilities *(who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	HFS MCOs Incident reports submitted to HFS or MCOs within 72 hours. State will review and respond within 5 business days. If a Corrective Action Plan (CAP) is needed, it must be provided to HFS or the appropriate MCO within 15 business days. HFS or the MCO will respond within 15 business days. Remediation must be completed within 30 business days after the response from HFS or the MCO.
Frequency *(of Analysis and Aggregation)*	Continuous and ongoing.

Requirement	7b) The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	The number and percent of CCSOs who have policies and procedures to prevent incidents of abuse, neglect, and exploitation. N = number of CCSOs with policies and procedures to prevent incidents of abuse, neglect, and exploitation. D = Total number of CCSOs with policies and procedures reviewed.
Discovery Activity *(source of data & sample size)*	Source of Data = CCSO policies and procedures. 100% of CCSOs will have their policies and procedures reviewed.
Monitoring Responsibilities	University Partner MCOs

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

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

Methods and Standards for Establishing Payment Rates

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

The agency's fee schedule rate will be set as of July 1, 2022, and is effective for services provided on or after that date. All rates are published on the Department's website located at http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/.

☐	HCBS Case Management	
☐	HCBS Homemaker	
☐	HCBS Home Health Aide	
☐	HCBS Personal Care	
☐	HCBS Adult Day Health	
☐	HCBS Habilitation	
☒	HCBS Respite Care	
	HCBS Respite Care rates are on a fee schedule and were established by comparing the services to similar covered Medicaid services. Reimbursement is made at the lesser of the usual and customary charge to the general public or statewide maximum established by the Department. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.	
For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☒	Other Services (specify below)	
	HCBS Family Peer Support	

	HCBS Family Peer Support rates are on a fee schedule and were established by comparing the services to similar covered Medicaid services. Reimbursement is made at the lesser of the usual and customary charge to the general public or statewide maximum established by the Department. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.
	HCBS Intensive Home-Based Services HCBS Intensive Home-Based Services are on a fee schedule and were established by comparing the services to similar covered Medicaid services. Reimbursement is made at the lesser of the usual and customary charge to the general public or statewide maximum established by the Department. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.
	HCBS Care Coordination & Support (CCS) Care Coordination and Support Services will consist of two methods of reimbursement: a monthly Care Coordination case rate and event-based reimbursement for Crisis Response services. The Care Coordination monthly case rate will be established consistent with service requirements defined by the Department and published on a standardized fee schedule for Care Coordination and Support Organizations (CCSOs). Monthly case rates may take into consideration the following factors: • Salaries and benefits for direct care staff, required supervisory staff, and administrative staff; • Client: staff ratios; • Time spent in delivery of services; • Anticipated administrative costs; • Estimated number of clients to be served monthly; and • Time/distance standards for accessing care. The established Care Coordination monthly case rate will be reviewed to determine if adjustments to the rate are necessary every three years. The delivery of CCS services will be monitored using a fidelity monitoring tool administered by the UP as well as through regular reporting from the CCSO to the Department and its contracted MCOs to ensure that CCSOs are delivering the services covered under the established monthly case rate. Rates for event-based Crisis Response were established by comparing the services to similar covered Medicaid services. Reimbursement is made at the lesser of the usual and customary charge to the general public or statewide maximum established by the Department. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.
	HCBS Therapeutic Mentoring HCBS Therapeutic Mentoring rates are on a fee schedule and were established by comparing the services to similar covered Medicaid services. Reimbursement is made at the lesser of the usual and customary charge to the general public or statewide maximum established by the Department. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers.
	HCBS Therapeutic Support Services HCBS Therapeutic Support Services are reimbursed at cost to qualified providers approved by the CCSO to render services. As part of the prior authorization process for this service, the CCSO shall verify the cost of the service, that the provider delivering the service is charging their usual

	and customary rate, that the services are not duplicative and/or available under other Medicaid spending authorities available to the recipient, and that the service being requested is not otherwise free to the public. The CCSO shall have policies and procedures to ensure that these services are verified and to account for all funds to ensure that annual recipient spending limits are not exceeded.
	HCBS Individual Support Services HCBS Individual Support Services are reimbursed at cost to qualified providers approved by the CCSO to render services. As part of the prior authorization process for this service, the CCSO shall verify the cost of the service, that the provider delivering the service is charging their usual and customary rate, that the services are not duplicative and/or available under other Medicaid spending authorities available to the recipient, and that the service being requested is not otherwise free to the public. The CCSO shall have policies and procedures to ensure that these services are verified and to account for all funds to ensure that annual recipient spending limits are not exceeded.

State: Illinois

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