

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:

Illinois Supportive Living Program

C. Waiver Number: IL.0326

Original Base Waiver Number: IL.0326.90

D. Amendment Number: IL.0326.R04.03

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

01/01/20

Approved Effective Date: 01/01/20

Approved Effective Date of Waiver being Amended: 10/23/17

2. Purpose(s) of Amendment

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

The Illinois General Assembly and Governor amended 305 ILCS 5/5-5.01 to link Supportive Living Program rates to the average total nursing facility services per diem. The new language reads, "Subject to federal approval, the Medicaid rates for supportive living services on and after July 1, 2019 must be at least 54.3% of the average total nursing facility services per diem for the geographic areas defined by the Department while maintaining the rate differential for dementia care and must be updated whenever the total nursing facility service per diems are updated". Rates for nursing facilities are updated quarterly. The average increase for assisted living services is 21%.

Number of unduplicated residents revised based on FY18 utilization. The estimated decrease in participation is a reflection of delays with the development of approved sites; attributed to zoning and financing challenges.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Waiver Application	
<input type="checkbox"/> Appendix A Waiver Administration and Operation	
<input checked="" type="checkbox"/> Appendix B Participant Access and Eligibility	B-3-a
<input type="checkbox"/> Appendix C Participant Services	
<input type="checkbox"/> Appendix D Participant Centered Service Planning and Delivery	
<input type="checkbox"/> Appendix E Participant Direction of Services	
<input type="checkbox"/> Appendix F Participant Rights	
<input type="checkbox"/> Appendix G Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input checked="" type="checkbox"/> Appendix I Financial Accountability	I-2
<input checked="" type="checkbox"/> Appendix J Cost-Neutrality Demonstration	J-1, J-2-a, J-2-b, J-2-c-i, J-2-d-ii

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

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

[Empty rectangular box]

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

1. Request Information (1 of 3)

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

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

Illinois Supportive Living Program

C. Type of Request: amendment

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

- 3 years 5 years

Original Base Waiver Number: IL.0326

Waiver Number: IL.0326.R04.03

Draft ID: IL.005.04.03

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/17

Approved Effective Date of Waiver being Amended: 10/23/17

1. Request Information (2 of 3)

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

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

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

[Empty rectangular box]

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

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

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

[Empty rectangular box]

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

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

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

--

1. Request Information (3 of 3)

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

Select one:

- Not applicable
 Applicable

Check the applicable authority or authorities:

- Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I
 Waiver(s) authorized under §1915(b) of the Act.

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

A companion 1915(b) waiver was approved 5/28/14 with an expiration date of 5/31/19. This waiver amendment does not make any revisions to the Integrated Care Program and Medicare Medicaid Alignment Initiative managed care delivery programs.

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

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

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

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

The Illinois IL.13-015 1932(a) State plan amendment (SPA) to implement mandatory managed care for the adult aged, blind and disabled populations in Cook County and surrounding border counties was approved for the effective date of May 1, 2011.

The State enrolls Medicaid beneficiaries on a mandatory basis into managed care organizations (MCOs) through the HealthChoice Illinois, which is a full-risk capitated program.

The SPA is operated under the authority granted by section 1932(a)(1)(A) of the Social Security Act. Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness, freedom of choice or comparability. The authority will not be used to mandate enrollment of Medicaid beneficiaries who are Medicare eligible, or who are Indians, except for voluntary enrollment as indicated in D.2.ii of the SPA.

- A program authorized under §1915(i) of the Act.
 A program authorized under §1915(j) of the Act.
 A program authorized under §1115 of the Act.

Specify the program:

The MMAI operates pursuant to Section 1115A of the Social Security Act.

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The IL Supportive Living Program (SLP) services (svcs). individuals (indiv.) ages 65 and older and persons with physical disab. ages 22-64 who are in need of assistance (asst.) with activities of daily living (ADL). SLP providers (prov.) must have apartments (apts.) with a lockable entry door, living area, bedroom, kitchen and a bathroom that affords privacy. Participants (partic.) only share double occupancy apartments by choice. Partic. may receive visitors of their choice at any time. Partic. come and go from their apt. and the building as they choose. Partic. may obtain employment, volunteer, shop and pursue any activities (activ.) they like in the community. Common areas in the building are accessible to all and allow for dining, socialization, computer access and partic. personal use.

The SLP prov. supplies partic. with individualized svcs., including: medication oversight, routine health assessments by licensed nurses, well-being checks, asst. with ADLs, laundry, housekeeping, social and health promotion activ. and arranging for necessary outside svcs.

Access to the community is promoted through activ. both onsite and outside of the SLP. Opportunities for community involvement are communicated to partic. in the form of calendars, newsletters, email and also verbally. Examples of activ. that provide an opportunity for community access outside of the SLP include: musical events, religious services, educational and charity opportunities, sporting events, shopping, museum trips and scenic drives. Partic. are encouraged to provide input re. activ. SLP prov. also encourages indiv. participation in the community, such as visiting friends, volunteering or taking classes. The required partic. assessment includes identifying a person's interests. Additionally, the community is invited to be a part of activ.. Examples include presentations by medical professionals, children, musical groups and faith based groups.

The purpose of the SLP is to promote the health and independence of partic. by offering the necessary supports and services. The SLP is an alternative to nursing facility care and also to living alone in the community where comprehensive support svcs. may not be available.

SLP dementia care settings afford individuals with cognitive impairments the option to remain in a community setting while providing the added safety intervention of alarmed, delayed exit doors. All of the services and requirements in a conventional SLP setting are followed along with well-being checks three times daily, scheduled activities at least three times daily, increased staffing and additional staff training. Participants are assessed prior to admission and quarterly thereafter to verify the need for alarmed, delayed exit doors as a needed safety intervention. If a participant is assessed and determined not to need this intervention, they/their designated representative are provided referral information to other service options, including a conventional SLP setting.

The Goals of the SLP include:

Health and Safety

Many partic. enter the SLP directly from their own home where they might not be receiving regular assist. with supports, such as medication oversight, meals, hygiene, well being checks and overall health monitoring. The SLP provides these svcs., which assist partic. with maintaining their health and independence.

Quality of Life

Partic. who previously resided in skilled nursing facilities are able to experience more freedom and are encouraged to be more independent in a SLP building. They are free to come and go, decorate their apt., participate in activities of their choosing, cook meals or eat in the dining room. Partic. also are involved with the develop. of an individualized service plan, which reflects the svcs. and care they need and prefer, along with any svcs. they refuse. Additionally, partic. who previously lived in their own homes may have been isolated and not had regular opportunities for interaction with others and their community. The SLP encourages socialization within the SLP and with the community at large.

Increased Service Options

The SLP provides partic. with another option for support svcs. that promote health and safety and encourage independence. The licensed Assisted Living Program in IL is not subsidized by public funds and therefore is not an affordable option for many people. Independent living and subsidized housing do not offer many of the supports waiver partic. need, such as medication oversight. Without the SLP, nursing facilities are the only other care option for many people of low income who require more services than they can obtain in their home.

Cost Savings

With a Medicaid reimbursement rate less than that of nursing facilities, the SLP decreases the State's cost of care for partic. who otherwise would be institutionalized. One main objective of the SLP is to decrease or divert individuals from nursing facilities who do not need skilled services.

The Dept. of Healthcare & Family Services is the State Medicaid agency (SMA) and is responsible for oversight of the SLP. Svcs. are accessed on the local level at individual SLP providers. Applications for Medicaid are also made at the state level at the Dept. of Human Services, Family and Community Resource Centers located throughout the state and online.

Partic. are encouraged to make their own decisions about the svcs. they receive. The svcs. provided are based on the partic.'s individual needs and preferences and are supplied in accordance with the person centered service plan.

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- Yes. This waiver provides participant direction opportunities. *Appendix E is required.*

No. This waiver does not provide participant direction opportunities. *Appendix E is not required.*
- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewideness.** Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):

- No
 Yes

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

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

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

5. Assurances

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

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-1 must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to

the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

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

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

WAIVER AMENDMENT FOR RATE METHODOLOGY:

Public notice was issued on August 22, 2019 via the SMA's website at:

<https://www.illinois.gov/hfs/SiteCollectionDocuments/082219SLPwaiverPublicNoticerate.pdf>. Those interested in providing input were asked to send their feedback via email to HFS.HCBSWaiver@illinois.gov or via U.S. mail to the Department of Healthcare and Family Services, ATTN: Waiver Management, 201 South Grand Avenue East, 2nd Floor, Springfield, IL 62763. A non-electronic public notice was available at local Department of Human Services offices and in Cook County at the SMA's Director's office. A hard copy of the waiver renewal was available for download and in hard copy at the HFS offices identified in the public notice. Public comments were accepted through 9/21/19.

On August 23, 2019, the SMA informed via email and sought feedback from our representative of the Tribal Authority of First Nation of Illinois' intent to amend this waiver. The SMA offered to answer any questions. Evidence of notification is available through the SMA.

The SMA sent an email to SLP providers which included a copy of the waiver amendment informing them of the public notice.

One comment was received from the Affordable Assisted Living Coalition (AALC).

Comment:

On behalf of our membership, I strongly support the changes made in the proposed amendment. The new methodology will not only increase funding but by linking the rate to nursing homes, it will secure the balance between supportive living and nursing home services.

Response:

The Department thanks the AALC for its comment.

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

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

August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Zip:

Phone: Ext: TTY

Fax:

E-mail:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:
State: **Illinois**
Zip:
Phone: Ext: TTY
Fax:
E-mail:

8. Authorizing Signature

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

Signature:
 State Medicaid Director or Designee

Submission Date:

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

Last Name:
First Name:
Title:
Agency:
Address:
Address 2:
City:
State: **Illinois**
Zip:

62763

Phone:

(217) 782-2570

Ext:

TTY

Fax:

(217) 782-5672

E-mail:

Attachments

doug.elwell@illinois.gov

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

- The Medical Assistance Unit.**

Specify the unit name:

Division of Medical Programs

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

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

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

Local Case Coordination Units perform initial level of care evaluations.

Illinois' mandatory managed care program, now called HealthChoice Illinois, will operate statewide for waiver participants effective January 1, 2019 offering providers the opportunity to contract with managed care plans in all Illinois counties; numerous managed care plans will be available in Cook County. The Integrated Care Program (ICP), Family Health Plan/ACA Adults (FHP/ACA) and Managed Long Term Services and Supports (MLTSS) managed care programs are now incorporated in HealthChoice Illinois. Members enrolled in the Medicare Medicaid Alignment Initiative (MMAI) are not impacted by HealthChoice Illinois. For those waiver participants enrolled in a Managed Care Organization (MCO), the Plans will be responsible for care coordination, service plan oversight, participant safeguards, prior authorization of waiver services, and quality assurance and quality improvement activities.

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

Appendix A: Waiver Administration and Operation

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

- Not applicable**

- Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.**

Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

The SMA reviews the screening results forms completed by local Case Coordination Units for all new Supportive Living Program waiver participants annually.

In the SMA's contracts with MCOs that provide waiver services, the SMA has specified for each waiver performance measure the following: responsibility for data collection, frequency of data collection/generation, sampling approach, responsible party for data aggregation and analysis, frequency of data aggregation and analysis, data source and remediation. For each performance measure, the data source varies according to the performance measure. For many measures, the sources are MCO reports and External Quality Review Organization (EQRO) medical record reviews.

The data source for several measures includes the outcomes of survey respondents to customer satisfaction and quality of life surveys. MCOs collect this data either by evaluating 100% of records or through a representative sample of records, according to the specific performance measure.

MCOs are required to submit quarterly reports, using the format required by the SMA on specific performance measures described in the SMA's contracts with the MCOs. For each performance measure, contracts specify required elements and format such as the numerators, denominators, sampling approaches and data sources. The SMA has provided the MCOs with a template Workbook for their use in submitting quarterly reports. Each performance measure has its own tab within the Workbook and captures quarterly information across the reporting year. MCOs present the results to the SMA in quarterly meetings. MCO contracts include sanctions for failure to meet requirements for submissions of quality and performance measures.

The SMA contracts with Health Services Advisory Group (HSAG) to serve as EQRO. As part of the SMA's quality oversight and monitoring of the waiver providers, HSAG performs quarterly onsite audits of the enrollee care plans through record reviews. Per the SMA's contract with HSAG, upon completion of the reviews, HSAG provides an enrollee specific summary of findings by measure and a waiver specific summary report of findings and recommendations as appropriate. The report includes: Summary of non-compliance related to specific performance measures; Overall summary of record review findings; and Recommendations for remediation of non-compliance. HFS and HSAG subsequently and collaboratively work to follow-up with MCOs to ensure remediation occurs within the required timeframes.

Appendix A: Waiver Administration and Operation

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

The State Medicaid agency (SMA) reviews the screening results forms of all new waiver participants annually. These forms are completed by Case Coordination Units. SMA staff audit the forms to verify they are complete and accurate.

Oversight of MCOs:

The State's Quality Improvement System (QIS) has been modified to assure that the MCOs are complying with the federal assurances and performance measures that fall under the functions delegated to them by the SMA. The sources of discovery vary, and the sampling methodology for discovery is based on either 100% review or the use of a statistically valid proportionate and representative sample. The type of sample used is indicated for each performance measure. The SMA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The SMA pulls the sample annually and will adjust the methodology as additional MCOs are enrolled to provide long term services and supports.

Once the SMA selects the sample, it is provided to the External Quality Review Organization (EQRO), the entity responsible for monitoring the MCOs. The EQRO determines a review schedule based on the MCO sample sizes and performs onsite reviews for those measures that require a record review. The EQRO sends a report of findings to the SMA and the MCOs. The MCOs are required to remediate findings within required timelines. The MCOs report remediation activities to the SMA at least quarterly.

For the performance measures that do not require record reviews, the MCOs send routine reports (some monthly and some quarterly) to the SMA. These reports contain discovery and remediation activity and are reviewed at least quarterly. Data sources may include the Medicaid Management Information System (MMIS), the MCO's Information Systems, the MCO's critical incident reporting systems and other data sources as indicated in the waiver.

The SMA meets quarterly with the MCOs to discuss compliance with the waiver assurances and to identify and analyze trends based on scope and severity. Remediation activities are reviewed and systems improvements, if necessary, are implemented.

As part of the State's oversight of the EQRO, the SMA has developed a performance measure to assure that the EQRO is completing record reviews as required through its contract. If non-compliance is noted, the EQRO is asked to develop a corrective action plan to remediate the problem .

Appendix A: Waiver Administration and Operation

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

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Function	Medicaid Agency	Contracted Entity
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

#/% of new waiver participants' screening results forms submitted by CCU or DHS Division of Rehabilitation Services (DRS) as part of the level of care process that were complete and accurate. Num: Number of new waiver participants with screening results forms submitted by CCU or DRS that were complete and accurate. Den: Total number of screening results forms for new waiver participants.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

<i>each that applies):</i>	<i>each that applies):</i>	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

#/% of new dementia prog. waiver partic. screening results forms submitted by CCU or DHS Div. of Rehab. Services (DRS) as part of the level of care determination process that were complete and accurate. Num: # of new dem. prog. waiver partic. with screening results forms submitted by CCU or DRS that were complete and accurate. Den: Total # of screening results forms for new dem. program partic.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify:	

--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

#/% of SLP providers utilized by the MCOs that are enrolled Medicaid providers.

Numerator: Number of SLP providers utilized by the MCOs that continued to maintain certification. Denominator: Total number of enrolled certified SLP providers utilized by the MCOs.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MCO Reports

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

<input checked="" type="checkbox"/> Other Specify: <input type="text" value="MCO"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of participant reviews conducted by the EQRO according to sampling methodology specified by the waiver. Numerator: Number of participant reviews conducted by the EQRO according to the sampling methodology specified in the waiver. Denominator: Total

number of participant reviews by the EQRO required according to the sampling methodology.

Data Source (Select one):

Other

If 'Other' is selected, specify:

EQRO Reports

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">EQRO</div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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

The SMA will conduct routine programmatic and fiscal monitoring for the MCOs.

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

For the MCO, the SMA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The SMA will pull the sample annually and adjust the methodology as additional MCOs are enrolled to provide long term services and supports.

b. Methods for Remediation/Fixing Individual Problems

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

PM 1 & 2:
 If a new waiver participant's screening results form is found to be incomplete or inaccurate, the SMA provides a copy of the form to the Department on Aging (DoA) for local Case Coordination Units (CCU) or the Department of Human Services (DHS) for the Division of Rehabilitation Services (DRS). DoA or DHS notifies the appropriate screening staff to bring errors to their attention so the non-compliance can be reviewed and any necessary remediation be completed. If the non-compliance results in a non-payable service period for the waiver participant or a determination that the participant was ineligible for waiver services, the SMA would recover payment. If persistent problems with specific CCU or DHS employees were identified, the SMA would seek a meeting with the respective state agency to discuss continuous quality improvement activities, such as staff training or personnel action.

PM 3:
 Upon discovery of an MCO utilizing a provider that is not an enrolled Medicaid provider, the MCO is notified to transfer participants. SMA staff would assist with identifying other providers, including SLP providers. Remediation shall occur immediately. The MCO would need to implement a plan of correction. Payment recovery by the SMA could occur.

PM 4:
 The EQRO completes case reviews and reviews the scheduling/process to determine reasons for reviews not being conducted. If remediation is not within 90 days, the EQRO reviews procedures and submits a plan of correction to the SMA. The SMA agency would follow-up to verify completion .

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

- No
- Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	22	64	
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			<input type="checkbox"/>
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

Potential Supportive Living Program (SLP) waiver participants must also be screened and meet nursing facility level of care. The SLP does not exclude specific diagnoses, as long as the eligibility requirements are met and the person is appropriate for placement with the SLP provider. The State will use PASRR reviewers to assess for persistent risks and needs to inform whether the person is appropriate for placement with the SLP provider.

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

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

Specify:

Supportive Living Program providers serving persons with physical disabilities do not have a maximum age limit after resident is admitted. Although the participant cannot be older than age 64 at the time of admission, participants are able to remain at the SLP provider after that age.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage:

- Other**

Specify:

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

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

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

- The following dollar amount:**

Specify dollar amount:

The dollar amount (*select one*)

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

Specify the formula:

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

Specify percent:

- Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- The participant is referred to another waiver that can accommodate the individual's needs.
- Additional services in excess of the individual cost limit may be authorized.

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

- Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	12132
Year 2	12465
Year 3	11980
Year 4	12262
Year 5	12453

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

The waiver provides for the entrance of all eligible persons.

Participants in the Supportive Living Program (SLP) waiver must be age 65 years or older, or ages 22-64 and have a physical disability, as determined by the Social Security Administration. The SLP also offers a dementia program at specially certified providers. Any person who meets all other program requirements and displays/exhibits symptoms related to internal pathological changes in the brain that affect intellectual and social abilities severely enough to interfere with daily functioning which makes it unsafe for them to reside by themselves may be assessed for the SLP dementia program. Just like other SLP participants, dementia program participants do not require 24-hour skilled nursing care.

Potential participants must also be screened by the State Medicaid agency (SMA) or its designee and found to be in need of nursing facility level of care and appropriate for placement with a SLP provider.

All potential participants must be checked against two state and one national sex offender registration websites and have a tuberculin skin test in accordance with the Illinois Control of Tuberculosis Code.

Individuals participating in the SLP waiver cannot receive services from any other Home and Community Based Services waiver.

Potential participants must apply and be approved for Medicaid.

Finally, individuals must have the resources to pay for the cost of room and board and to receive a personal allowance, both of which are established by the SMA.

For participants enrolled in MCOs, State-established policies governing the selection of individuals for entrance to the waiver will remain the same as for all participants. Initial waiver eligibility will be conducted by the same entities as designated for those not enrolled in managed care and will be based on the same objective criteria. Selection of entrants does not violate the requirement that otherwise eligible individuals have comparable access to all services offered in the waiver.

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- §1634 State
 SSI Criteria State
 209(b) State

2. Miller Trust State.

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

- No
 Yes

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

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

- Low income families with children as provided in §1931 of the Act

- SSI recipients
- Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- Optional state supplement recipients
- Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

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

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy in 209(b) States (42 CFR §435.330)
- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Public Law 111-148 Patient Protection and Affordable Care Act:

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

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

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- A special income level equal to:

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)
- Specify percentage:
- A dollar amount which is lower than 300%.
- Specify dollar amount:
- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
- Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
- Medically needy without spend down in 209(b) States (42 CFR §435.330)
- Aged and disabled individuals who have income at:

Select one:

- 100% of FPL
- % of FPL, which is lower than 100%.
- Specify percentage amount:
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

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

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

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

- Use spousal post-eligibility rules under §1924 of the Act.
(Complete Item B-5-c (209b State) and Item B-5-d)
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- The following standard included under the state plan

(*select one*):

- The following standard under 42 CFR §435.121

Specify:

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

(*select one*):

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

Specify percentage:

A dollar amount which is less than 300%.

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the state Plan

Specify:

The maintenance allowance for waiver participants equals the maximum income an individual can have and be eligible under 42 CFR 435.217 group.

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable

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

Specify:

Specify the amount of the allowance (select one):

The following standard under 42 CFR §435.121

Specify:

Optional state supplement standard

Medically needy income standard

The following dollar amount:

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

- The amount is determined using the following formula:

Specify:

iii. Allowance for the family (select one):

- Not Applicable (see instructions)
- AFDC need standard
- Medically needy income standard
- The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- The amount is determined using the following formula:

Specify:

- Other

Specify:

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

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

Select one:

- Not Applicable (see instructions) *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- The state does not establish reasonable limits.
- The state establishes the following reasonable limits

Specify:

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

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

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

i. Allowance for the personal needs of the waiver participant

(select one):

- SSI standard
- Optional state supplement standard
- Medically needy income standard
- The special income level for institutionalized persons
- A percentage of the Federal poverty level

Specify percentage:

- The following dollar amount:

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

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

Specify formula:

- Other

Specify:

The maintenance allowance for the waiver participants equals the maximum income an individual can have and be eligible under 42 CFR 435.217 group.

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

Select one:

- Allowance is the same
- Allowance is different.

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

- a. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the

provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

Other

Specify:

The SMA has agreements with the Department on Aging and the Department of Human Services, Division of Rehabilitation Services to perform initial level of care determinations for potential waiver participants. The SMA conducts reevaluations annually.

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

As stated in 89 Ill Adm Code, Chap. II, Section 220.605, contractors of the Department on Aging who perform initial level of care evaluations for potential waiver participants must be:

1. A registered nurse, or have a Bachelor of Science in Nursing, or have a Bachelor degree in social science, social work or related field. One year of program experience which is defined as assessment, provision, and/or authorization of formal services for the elderly, may replace one year of college education up to and including four years of experience replacing a Baccalaureate Degree. OR
2. Be a licensed practical nurse with one year of program experience which is defined as assessment of and provision of formal services for the elderly and/or authorizing service provision.

The Department of Human Services, Division of Rehabilitation Services requires a Master's degree from a college or university program accredited by the Council on Rehabilitation Education (CORE); or a Master's degree from an accredited college or university in rehabilitation counseling, rehabilitation administration, clinical psychology, counseling psychology, deaf education, special education, social work, sociology, gerontology and nursing or a closely related field.

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

The entry point into the Supportive Living Program (SLP) waiver, or initial level of care determination, is through the Universal Screening process which became law on July 1, 1996 (Public Act 89-499). This law requires all individuals seeking admission to a nursing facility on or after July 1, 1996 to be screened to determine the need for nursing facility placement prior to being admitted. This screening is required regardless of income, assets or payment source. The standardized screening tool used for assessment is the Determination of Need Assessment (DON). Those individuals identified through the screening process as needing nursing facility level of care are afforded the opportunity to select a SLP provider as long as their needs can be met in that setting.

The necessity for long term care is based on the determined need for a continuum of home and community-based services that ultimately prevent inappropriate or premature placement in a group care facility. The extent and degree of an individual's need for long term care is determined on the basis of consideration of pertinent medical, social and psychological factors as measured by application of the DON.

The DON is composed of three parts: demographic, cognitive status and functional status. The Mini-Mental Status Examination (MMSE) Section includes eleven items. The first two items are used to measure a person's orientation. The third question tests the ability of the applicant to register, i.e. learn and remember new information. The fourth item measures the person's ability to attend to a task and perform a mental function. The fifth item measures the person's short term recall. Remaining items in this section test a person's basic ability to use and understand words.

The functional status section assesses the level of assistance a person requires with activities of daily living, including: eating, bathing, grooming, dressing, transferring, continence, managing money, telephoning, preparing meals, laundry, housework, outside of home, routine health, special health and being alone.

Reevaluations are performed annually by the SMA through examination of the participant's comprehensive assessment. The comprehensive assessment is completed by the SLP provider's registered nurse near the time of the waiver participant's admission and annually thereafter. It must also be updated as needed to reflect any significant changes in condition. The annual Level of Care Determination (LOCD) tool captures scores from specific sections of the comprehensive assessment, including: cognition, decision making, transferring, dressing, eating, toileting, personal hygiene, bathing, medication management, managing money, preparing meals/snacks, housekeeping and laundry. Assessments of these areas reflect services provided in the SLP waiver and used during initial level of care evaluation, which makes them relevant for reevaluation.

The initial and annual level of care criteria for participants enrolled in managed care is the same.

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

- The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.
- A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

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

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

As described in Section B 6 d, the Determination of Need (DON) is the standardized assessment tool used to perform initial level of care evaluations. Assessors complete the DON by asking questions of the potential waiver participant and/or his/her designated representative. Case Coordination Unit staff and Department of Human Services, Division of Rehabilitation Services staff completing the DON may request additional information from physicians and other healthcare providers.

Annual reevaluations for waiver participants are performed by the SMA. As described in Section B 6 d, sections of the comprehensive assessment are reviewed for each waiver participant. A Level of Care Determination form is completed to verify the waiver participant continues to require the services provided by the Supportive Living Program waiver. SMA staff may also interview the participant, his/her designated representative, other health care providers and SLP provider staff to obtain more information or clarification.

Waiver participants who do not meet level of care requirements based on the initial or the annual level of care evaluation are provided the opportunity to appeal the decision by the SMA.

For participants enrolled in an MCO, the annual reevaluation process is the same.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):
- Every three months
 - Every six months
 - Every twelve months
 - Other schedule
- Specify the other schedule:*

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):
- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
 - The qualifications are different.
- Specify the qualifications:*

State Medicaid agency staff performs reevaluations. Most are Health Facilities Surveillance Nurses whose qualifications are:

--Current licensure as a registered nurse in the State of Illinois.

--Graduation from an approved nursing education program resulting in an associate or a diploma degree in nursing and three years of professional nursing experience. OR

--Bachelor's degree in nursing and two years of professional nursing experience. OR

--Master's degree in nursing

Staff may also be a Medical Assistance Consultant II whose qualifications are:

-Knowledge, skill and mental development equivalent to completion of four years of college with courses in medical social work.

--Two years professional experience in fields related to medical social work.

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

SMA procedures require annual onsite certification reviews be completed for all Supportive Living Program (SLP) providers. Policy requires that an annual Level of Care Determination (LOCD) be completed for each waiver participant during these reviews. SMA supervisory staff track due dates for annual reviews to ensure they are conducted within 60 days of the SLP provider's certification date.

Before the annual onsite certification review, a list of current waiver participants residing with the SLP provider is compiled from the long term care database, which is part of MMIS. This list identifies who requires an annual level of care review. An automated LOCD tool is created that includes forms for each participant on the list from the long term care database. SMA staff completes the LOCD tool. The automated LOCD tool is reviewed after the annual onsite certification review to verify LOCDs were completed for each waiver participant or justification was included, such as a death.

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

The records of initial level of care evaluations are kept by the Case Coordination Units and the Department of Human Services, Division of Rehabilitation Services for a minimum of three years. Records of reevaluations completed by the State Medicaid agency are kept for a minimum of three years. For participants enrolled in a MCO, the Health Plans will also maintain a copy of the forms. The record retention requirements will be the same for the Health Plans as required by CMS. The minimum is three years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

Number/percent of new waiver applicants who have a required initial level of care assessment prior to admission. Numerator: Number of new waiver applicants who have a required initial level of care assessment prior to admission. Denominator: Total number of new waiver applicants requiring initial level of care evaluations.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	<input type="checkbox"/> Other Specify: 	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: 	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number/percent of new dementia program waiver applicants who have a required initial level of care assessment prior to admission. Numerator: Number of new dementia program waiver applicants who have a required initial level of care assessment prior to admission. Denominator: Total number of new dementia program waiver applicants requiring initial level of care evaluation.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100%

		Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

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

Performance Measures

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

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

Performance Measure:

Number/percent of enrolled waiver participants evaluated annually as specified in the approved waiver. Numerator: Number of enrolled waiver participants evaluated annually as specified in the approved waiver. Denominator: Total number of enrolled waiver participants who required annual evaluation.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Level of Care Determination form

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number/percent of enrolled dementia program waiver participants evaluated annually as specified in the approved waiver. Numerator: Number of enrolled dementia program waiver participants evaluated annually as specified in the approved waiver. Denominator: Total number of enrolled dementia program waiver participants who required annual reevaluation.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Level of Care Determination form

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

Performance Measures

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

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

Performance Measure:

Number/percent of new waiver participants' annual level of care (LOC) determinations completed accurately. Numerator: Number of new waiver participants' annual LOCD determinations completed accurately. Denominator: Total number of new waiver participants requiring annual LOC determinations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Level of Care Determination form

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence

		Interval = 95%
<input type="checkbox"/> Other Specify: 	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: 	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number/percent of new dementia program waiver participants' annual Level of Care

(LOC)determinations completed accurately. Numerator: Number of new dementia program waiver participants' annual LOC determinations completed accurately. Denominator: Total number of new dementia program waiver participants' LOC determinations reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Level of Care Determination form

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number/percent of waiver participant annual LOC determinations completed by qualified Department staff. Numerator: Number of waiver participants with annual LOC determinations completed by qualified Department staff. Denominator: Total number of waiver participant LOC determinations completed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Level of Care Determination form

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

Number/percent of dementia program waiver participant annual level of care (LOC) determinations completed by qualified Department staff. Numerator: Number of dementia program waiver participants with annual LOC determinations completed by qualified Department staff. Denominator: Total number of dementia program waiver participant annual LOC determinations completed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Level of Care Determination form

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

b. Methods for Remediation/Fixing Individual Problems

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

Remediation for Initial Level of Care (LOC) Assessments:

When it is discovered that an initial LOC assessment has not been completed for a waiver participant, the LOC assessment is completed. If a participant is found ineligible, he/she is notified in writing by the SMA and provided appeal rights. Supportive Living Program (SLP) provider staff would assist the person with relocation assistance to another program or setting of the individual's choice.

Regardless of eligibility for waiver services, the SMA recovers all reimbursements paid for identified non-payable service periods as the result of initial LOC evaluation not being completed prior to admission to the waiver program. SMA staff change the date of eligibility for waiver services in MMIS to correspond with the first day of the allowable service period. Any claims prior to the allowable service period are voided. For service periods that begin after the first day of the month, the SLP provider would then submit a new claim for the allowable days for that month.

Additionally, the SLP provider may have to develop and implement a plan of correction. The SMA performs a follow-up review to determine compliance with initial LOC assessment requirements. Ongoing non-compliance results in sanction, including but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

Remediation for Annual Level of Care Assessments:

When it is discovered that an annual LOC has not been completed for a waiver participant, the LOC assessment is completed. If a person is found to be ineligible for waiver services during an annual LOCD assessment, he/she is notified in writing by the SMA and provided appeal rights. SLP provider staff would assist the person with relocation assistance to another program or setting of the individual's choice.

Remediation for Annual Level of Care (LOC) Assessments that do not support Initial LOC Assessments:

When it is discovered that an annual LOC assessment does not support the Initial LOC and the person is found ineligible for waiver services, he/she is notified in writing by the SMA and provided appeal rights. Supportive Living Program (SLP) provider staff would assist the person with relocation assistance to another program or setting of the individual's choice.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

No

Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

At the time of the initial level of care evaluation, all potential waiver participants (or their designated representatives) are informed of feasible service options for either institutional care or waiver services. The Illinois Department on Aging Choices for Care Assessment form is used for this purpose. Section C., Service Selection and Applicant/Client Certification states, "I have been advised that I may choose community-based services, supportive living facility services or nursing facility placement. I understand that I have the right to change my mind at any time." Services listed are: The Department on Aging's Community Care Program waiver, Department of Human Services waiver for persons with physical disabilities, the Supportive Living Program waiver or nursing facility placement. The participant indicates their service option choice with a check mark and signs his/her name. The Department on Aging's local Case Coordination Units, Department of Human Services, Division of Rehabilitation Services Rehabilitation Counselors are responsible for the completion of this form.

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

Copies of the Illinois Department on Aging Choices for Care Assessment Form are kept by local Case Coordination Units and Department of Human Services, Division of Rehabilitation Services. The Medicaid agency maintains copies of forms for private pay residents converting to the waiver. For participants enrolled in a MCO, the Plans will maintain the Freedom of Choice forms.

Appendix B: Participant Access and Eligibility

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

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

Providers of the Supportive Living Program waiver serving Limited English Proficient (LEP) persons are required to take steps to ensure equal access to services for participants. Acceptable practices include: hiring bi-lingual staff, hiring persons or contracting with interpreters, engaging community volunteers or using available technology, such as language translator applications. Written materials provided to residents or their designated representatives must be in a language and format they can understand. For participants enrolled in a MCO, the Plan shall make all written materials distributed to English speaking enrollees, as appropriate, available in Spanish and other prevalent languages, as determined by the State Medicaid agency. Where there is a prevalent single-language minority within the low income households (5% or more) where a language other than English is spoken, the Plan's written materials must be available in that language as well as English.

Appendix C: Participant Services

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

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

Service Type	Service		
Other Service	Assisted Living		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assisted Living

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Personal care and supportive services that are furnished to waiver participants who reside in a homelike, non-institutional setting that includes 24-hour onsite response capability to meet scheduled or unpredictable participant needs and to provide supervision, safety and security. Services also include social and recreational programming and medication assistance. Additionally, medication administration, intermittent nursing services and periodic nursing evaluations are provided. Transportation for activities must be supplied, as well as arrangement for transportation to scheduled medical appointments. Additionally, Personal Emergency Response Systems (PERS) are required in participant apartments and common areas of the building. The system is connected to a Supportive Living Program (SLP) provider's emergency call system monitored by nursing and response personnel. Other services include: well-being checks, laundry, housekeeping, three meals per day, snacks, maintenance, assistance with shopping and assistance with access to the larger community. Services that are provided by third parties must be coordinated with the SLP provider.

Case management services are provided to assist participants in gaining access to needed waiver and other State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not made for 24 hour skilled care. Nursing services required in the Supportive Living Program (SLP) include: assessments, service plan development/approval and implementation, health promotion or disease prevention counseling and teaching self-care, medication set-up and medication administration. The use of home health services are also allowed in the SLP, as ordered by a physician, but is not a required service. SLP provider staff are expected to coordinate care and services with home health care providers. This includes, among other skilled services, wound care and physical and occupational therapy. SLP providers must assist participants with obtaining such services.

Access to the larger community is encouraged and is achieved through scheduled activities and assistance with individual preferences with regard to community involvement. Activities in the larger community may include volunteer/charity opportunities, musical presentations, religious program, sporting events, shopping, cultural destinations and outdoor activities like walking groups and fishing. Additionally, community members are involved with SLP participants by attending/providing onsite events. Medical professionals provide information on health and wellness, children's groups offer music and social interaction and faith-based groups supply spiritual programs. Opportunities for community involvement are communicated to participants both in writing through activity calendars and newsletters, as well as verbally. Additionally, as part of the participant's assessment, their interests and hobbies are identified to help SLP provider staff assist with community involvement.

All assisted living services are provided by employees of the SLP provider. Staff provides individualized participant services based on the comprehensive assessment and a participant's preferences as determined through the service planning process. All participants are entitled to receive all of the services provided by the SLP. Participants and others of their choosing, such as a family member, are involved with the development of the service plan. Participants are able to identify which services they would like to receive and the frequency of services. The SMA monitors SLP providers to ensure that individualization occurs and verifies that participant care needs are being met. This monitoring occurs during annual onsite certification reviews and complaint investigations.

Payment for the SLP is calculated on a flat daily rate for each day a participant resides with a SLP provider and is eligible for Medicaid. Payment is not based on the frequency or the type of service provided. The type and frequency of services provided is included in the participant's service plan. Federal Financial Participation is not available for room and board, items of comfort or convenience, or the cost of building maintenance, upkeep and improvement. The methodology by which the cost of room and board are excluded from payments for SLP services is described in Appendix I-5.

Participants in the dementia program receive modified waiver services to meet their care needs. Modified services include: well-being checks three times per day (at least one per shift), at least three scheduled activities per day and alarmed, delayed exit doors as a safety intervention. Dementia units also have secured outdoor areas for use by participants. Participants are evaluated at the time of admission and quarterly thereafter to assess the continued need for the alarmed, delayed exit doors as a safety intervention.

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

There are no limits on the amount, frequency or duration of assisted living services being provided to waiver participants. Supportive Living Program providers must meet the scheduled and unscheduled needs of waiver participants (89 IL Admin. Code, Chap 1, Section 146.230 a). Payment is not made for 24-hour skilled care.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supportive Living Program Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assisted Living

Provider Category:

Agency

Provider Type:

Supportive Living Program Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Supportive Living Program (SLP) providers are certified by the SMA. A wide range of factors are examined for SLP providers, such as: financial stability, business experience, knowledge and experience in working with the elderly and persons with physical disabilities, record of non compliance with other state programs and property site control. Certification occurs initially when a SLP provider becomes operational and can admit waiver participants. It continues on an annual basis through an on-site review process. Initial certification by the SMA involves the review and approval of resident contracts, policies and procedures, emergency plans and quality assurance plans. Additionally, an on-site visit allows for the examination of approved local inspections, as well as the identification of compliance with required structural components, building maintenance and cleanliness, working building systems, staff background checks, qualifications and training. Final certification requires a review of waiver participant records, apartment observations and interviews. An annual certification review combining the components of the initial and final certification processes is conducted at each SLP provider. Annual certification reviews determine if providers are in compliance with program requirements.

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid agency.

Frequency of Verification:

The State Medicaid agency verifies provider qualifications at the time of initial certification and during annual on-site annual certification reviews conducted for all Supportive Living Program providers.

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- As an administrative activity.** *Complete item C-1-c.*
- As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Case management responsibilities are shared by the SMA and Supportive Living Program (SLP) providers. Each entity has a specific role and duties. SLP provider staff is required to complete scheduled assessments (assess.) initially, quarterly and annually. Assess. are also performed if a participant (partic.) experiences a significant change in condition. SLP providers must develop and implement individualized service (svc.) plans based on partic.s' needs and preferences identified in the assess. and voiced by the partic.. Svc. plans are required to be revised when a significant change in condition occurs and reviewed in conjunction with quarterly and annual assess. Additionally, SLP providers must provide assist. with arranging for and coordinating outside svcs. for waiver partic. . Examples include: home health svcs. and physician visits. Ancillary svcs. are another case management component supplied by SLP providers. Staff must arrange transportation for waiver partic. to medical appts. and offer to help with activities like shopping.

The SMA performs case management svcs. by conducting annual level of care determinations for all waiver partic., reviewing partic.s' assessments and svc. plans, addressing problems in svc. provision, monitoring the implementation of svc. plans and observing partic. health and safety.

The SMA staff monitors and provides oversight for SLP case management functions. During annual on-site certification reviews, records of a sample of waiver partic. are reviewed. The SMA verifies partic. assess. were done timely and completed accurately and thoroughly. Svc. plans must be individualized and contain all of the partic.'s needs and preferences. This includes any outside svcs. that are being provided. Progress notes, physician orders and other documentation in the record are also used to verify case management svcs. Partic. interviews are conducted, too.

For partic. enrolled in an MCO, case management for overall health care, including waiver svcs., is the the responsibility of the Plans. MCOs use a variety of tools to collect information about their member's physical, psychological and social health, including health risk screenings, claims data, referrals, service authorizations, transition information, level of care information, information from family members, caregivers, providers and other assess. tools. Health Risk Screenings must be completed within 60 days of enrollment. For HCBS members, the Health Risk Assessment (HRA) must be completed; timeframes vary for the HRA based on whether the member is already receiving HCBS services as a new member (180 days) transitioning from another health plan (90 days) or deemed newly eligible for HCBS services (15 days).

Additional functions that fall under case management for an MCO include providing case management for members and assisting those members in the development and implementation of a care plan. The care coordinator works in partnership with the SLP provider staff to make sure the care plan is comprehensive and person-centered. Care coordinators get support when necessary from a member's Interdisciplinary Care Team, a team made up of clinical and non-clinical staff whose skills and experience complement each other in the oversight of the member's needs.

The care coordinator works with the member to ensure the care plan:

- incorporates the member's medical, behavioral health, social, functional and community-based service needs are addressed
- Identifies short and long term treatment and goals to address the member's needs and preferences and to facilitate monitoring of a member's progress and evolving needs
- includes the opportunity for the member, PCP, other providers, family, etc. to participate and provide input into the care plan
- identifies risks, cultural preferences, preferred characteristics and language, living arrangements, barriers, community resources, desired outcomes, etc.

Appendix C: Participant Services

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

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

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

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

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

The Illinois Health Care Worker Background Check Act [225 ILCS 46](HCWBC Act) requires unlicensed employees of Supportive Living Program (SLP) providers with duties that involve or may involve contact with waiver participants, or access to the living quarters or the financial, medical or personal records of participants, to undergo a criminal background check. The 89 IL Adm in, Code Chap 1, Section 146.235(l) of the SLP Rules states, "The SLF shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLF shall knowingly hire, employ or retain any individual in a position with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLF may conditionally employ an applicant for up to three months pending the results of the criminal history record check".

The HCWBC Act requires fingerprint background checks be completed to identify disqualifying convictions in the State of Illinois. There is no time limit on the background check; any crime committed as an adult is included. Additionally, SLP providers must check sex offender and other criminal registries for all new employees, even those who have already had a qualifying background check. Prior to beginning employment, all unlicensed staff must be checked on the Health Care Worker Registry (Registry), which is maintained by the Illinois Department of Public Health. The Registry identifies if an individual has any disqualifying convictions that would prohibit them from working in a health care setting as defined in the HCWBC Act. If an individual is not listed on the Registry, he or she must go to a State contracted vendor to have their fingerprints collected. The fingerprints are then forwarded to the Illinois State Police. The Illinois State Police updates the Registry and employers are notified of the results. If an individual is convicted of a disqualifying offense after they are hired, the Illinois State Police updates the Registry and the employer is notified. Additionally, certified nurse aides are fingerprinted and added to the Registry as part of their certification.

Licensed staff employed by the SLP provider, including nurses and dieticians, must have proof of current licensure in the State of Illinois. Background checks for these individuals occur at the time of licensing and is overseen by the Illinois Department of Financial and Professional Regulation. SLP providers must maintain a copy of the current license for all licensed staff.

Annual on-site certification reviews are performed by the SMA for each SLP provider. The review includes verifying documentation of Registry and criminal background checks for 100% of employees hired since the previous review. This includes verifying termination of any individuals with disqualifying convictions. Compliance with the HCWBC Act can also be reviewed during on-site complaint investigations.

The SMA is responsible for certifying SLP providers initially and annually thereafter, including verifying staff certification, licensure and compliance with the Health Care Worker Background Check Act. MCOs can only contract with SLP providers certified by the SMA. Because of this, MCOs are not required to complete or verify background checks for SLP provider staff.

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

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

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request

through the Medicaid agency or the operating agency (if applicable):

The Health Care Worker Background Check (HCWBGC) Act [225 ILCS 46] requires unlicensed health care employees, including those employed by a Supportive Living Program (SLP) provider who have access to waiver participants, their apartments or their financial or medical records, to be checked on the Illinois Department of Public Health's (IDPH) Health Care Worker Registry prior to beginning employment. If the Registry indicates a fingerprint background check has not been completed, the potential employee must have their fingerprints collected. Once results are received, the information is forwarded electronically to the SLP provider and the Registry is automatically updated. If a required Registry check reveals a potential employee has a disqualifying criminal conviction and has not received a waiver from the IDPH, he/she cannot be employed by the SLP provider.

If a prospective employee does not have a current finger print check listed on the Registry, he/she must have their fingerprints collected within 10 business days of signing a designated authorization form. The authorization form must be signed prior to beginning employment. If the fingerprints are not collected within 10 days, the employee must be suspended. If fingerprints are not collected within 30 days, employment must be terminated.

The Department of Financial and Professional Regulation maintains licenses for professional staff, such as nurses and dietitians, and maintains a listing of these persons including current licensure status and any disciplinary actions. All licensed staff must have a current license with the State of Illinois.

Annual on-site certification reviews performed by the SMA at each SLP provider includes examining documentation of Registry checks and active licenses for employees hired since the previous review.

If an employee does not have fingerprints collected timely, the SMA instructs the provider to immediately remove the employee from the schedule until his/her fingerprints are collected. The employee must provide verification of the collection of their fingerprints before returning to work.

Appendix C: Participant Services

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

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Assisted Living	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Settings in this waiver will comply with federal HCBS requirements per Attachment #2 in this renewal application.

89 IL Adm in. Code, Section 146.210 outlines structural requirements for Supportive Living Program (SLP) providers that ensure a home-like setting for waiver participants. For instance, minimum square footage requirements for apartments ensure participants have comfortable living spaces. Each apartment must have a private bath, living, sleeping, cooking and dining areas. Additionally, each apartment must have a door that locks from the inside and individually controlled heating and cooling. Participants' kitchen areas must include a refrigerator, sink, stove or microwave for cooking and an area for dining. There must also be wiring for telephone and access to cable television or a master antenna. Participants are free to decorate their apartments to reflect their individual taste and style. Additionally, all residents have their own private apartment unless they choose to share a double occupancy apartment.

Common areas are also required in SLP settings to encourage and support participant socialization. Common areas may include private dining rooms, libraries, computer rooms, outside garden/patio areas, family rooms and chapels. Participant laundry rooms are required as well so that that participants may do their own laundry, if they choose. Common areas must be available for participants' use at any time.

Participants can come and go from their apartments and from the building. Note the dementia program has delayed egress. See Appendix G-2 Restrictive Interventions for more information. Additionally, participants are allowed visitors of their choosing at any time, including those in the dementia program.

Access to the larger community is available in the SLP setting. Participants may have their own vehicles with which to access the community. SLP providers may have transportation available or transportation may be available via public transit, local senior or disability advocacy groups or a private transportation company. Shopping trips are arranged at least weekly. Other scheduled activities may include: musical events, religious services, educational opportunities, charity/volunteer opportunities, sporting events, shopping, restaurants, museum trips, scenic drives and outdoor activities. Waiver participants are encouraged to provide input regarding community activities based on their preferences. SLP provider staff also encourage individual community participation, such as volunteering or opportunities for learning. The required comprehensive assessment also includes a section to identify a person's individual interests. Residents are able to access the community and participate in any community activities/events they wish. Additionally, community members are invited into SLP settings. Medical professionals provide information on health and wellness, children's groups provide musical and social entertainment. Faith-based groups and musical entertainers are also common guests.

Opportunities for community involvement are communicated to participants both in writing through activity calendars and newsletters, as well as verbally by staff.

The SMA is responsible for identifying restrictive interventions. Oversight activities occur during on-site visits, including annual certification reviews, complaint investigations, scheduled technical assistance visits and unannounced monitoring visits.

During on-site annual certification reviews, SMA staff reviews participant records and also interviews a representative sample of participants. Participants are asked if they have been informed and are aware of their rights. They are also asked about their satisfaction with the care they receive and if they know to whom they may register complaints. Additionally, during the record review, SMA staff has the opportunity to identify the use of restrictive interventions.

The use of restrictive interventions can also be brought to the SMA's attention at any time via the toll-free complaint hotline, email or written correspondence. Anyone, including participants, their families and provider staff, may register a complaint. Furthermore, the State Long Term Care Ombudsman Program would inform the SMA if staff became aware of or suspected the use of restrictive interventions by a SLP provider. SMA staff must perform on-site investigations in response to complaints received.

SMA staff may conduct scheduled and unscheduled visits for the purposes of monitoring and providing technical assistance to Supportive Living Program (SLP) providers. These visits offer another opportunity for

SMA staff to detect the use of restrictive interventions.

If an SLP provider was using restrictive interventions, the SMA would issue a finding of non-compliance. The SLP provider has 30 days to develop and implement a plan of correction from the date written notification of the non-compliance is issued. SMA staff performs an on-site follow-up review to verify the use of restrictive interventions is no longer being practiced. If non-compliance persists after a second follow-up review, the SMA could impose sanctions, including suspending or terminating the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff would assist waiver participants in identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a participant's health or safety was threatened by the use of restrictive interventions, the SMA could also issue a notice of immediate jeopardy. If a participant is at risk at the time of the on-site review, SMA staff remains at the SLP provider until the area of non-compliance associated with the immediate jeopardy has been abated. Immediate jeopardy also requires the SLP provider to submit and implement a plan of correction within ten days of receipt of the findings. SMA staff performs an on-site follow-up review to verify that remediation has occurred and that the SLP provider is in compliance with administrative rules. If non-compliance is identified, the SMA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants in identifying possible relocation options, including transferring to another SLP provider.

Dementia program participants' safety needs are met with a service intervention of alarmed, delayed exit doors. When the door's release bar is pushed, an alarm sounds. The door will open if the bar is pushed for several continuous seconds. Dementia participants have the freedom to move within the dementia care setting, including access to secured outdoor common space.

Participation in the dementia program is voluntary. The participant, his/her physician, family and dementia program staff collaborate to determine if the dementia program is a beneficial setting. The need for extra supervision is based on a participant's individual characteristics and needs for care and support. All dementia participants must have an elopement risk assessment completed prior to admission and quarterly thereafter by a registered nurse to determine if alarmed, delayed exit doors are a necessary safety intervention. If a participant is assessed to no longer require this intervention, SLP provider staff discusses a different community placement with the participant and his/her designated representative. SMA staff review elopement risk assessments during on-site certification reviews for all participants.

Dementia program participants are able to leave the dementia care setting at any time with staff, family or other designated individuals. SLP provider activities includes options both on-site and in the larger community. Dementia participants may also have visitors at any time. Visits by family and friends are encouraged and do not have to be prearranged with the SLP provider. SLP provider staff is available 24 hours per day to allow visitors access to the building.

SMA staff completes on-site annual certification reviews for the dementia program. SMA staff verifies that participants have been appropriately assessed for the needed safety intervention of alarmed, delayed exit doors. They also confirm assessments were timely, complete and accurate. Participant access to common areas is also verified. If program non-compliance is identified, the process outlined above for SLP providers is followed.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Assisted Living

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Assisted Living	<input checked="" type="checkbox"/>

Facility Capacity Limit:

300

Scope of Facility Standards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

- Self-directed
- Agency-operated

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

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

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

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

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

- Other policy.**

Specify:

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

The SMA does not limit the type of provider that may apply to the Supportive Living Program (SLP). An extensive process is utilized by the SMA to review applications from providers wishing to participate in the SLP. Provider qualifications are published in Department rules (89 IL Adm. Code, Chap I, 146.215) and are located at the Department's website.

To ensure quality services for waiver participants, the SMA employs a thorough review process for applicants. Interested providers must submit an application and may undergo an in-person interview with SMA staff. Basic information is collected on the application, such as: provider name, planned provider/building name, location, number of apartments and proposed number of residents. Other detailed information included in the application process and examined by the SMA includes:

- financial background and stability
- business experience/background
- knowledge and experience with providing services to the elderly and people with physical disabilities
- operating history with other health care programs
- record of non-compliance with state programs
- knowledge of requirements of the Supportive Living Program, its purpose and its goals
- strategic plan
- architectural drawings
- phase-one environmental study
- market feasibility
- criminal background/Medicare/Medicaid disbarment

Other state agencies, such as the Department on Aging, Department of Human Services and the Illinois Housing Development Authority may also be consulted during the review process. These agencies offer additional information regarding provider qualifications, service history and market area information.

An internal review of the application occurs simultaneously across several divisions of the SMA, with the agency's SLP coordinators overseeing distribution, tracking, review and recommendations returned to the SMA's Bureau of Long Term Care for processing. Once this portion of the review is completed, the applicant may be contacted to schedule a face-to-face interview. Questions related to experience with providing long term care or similar services or programs, familiarity with the SLP waiver and its services and overall plans for the proposed project are posed to the applicant.

Once an application is approved to proceed towards certification, the applicant is notified in writing by the SMA. The SMA may withdraw approval of an approved SLP application if the applicant fails to become operational within 24 months after the approval. Applicants are allowed to request extensions to this operational deadline.

Provider qualification can be found at <http://www.ilga.gov/commission/jcar/admincode/089/089001460B02150R.htm>.

For HealthChoice Illinois, MCOs shall enter into a contract with any willing and qualified provider in the Contracting Area that renders waiver services so long as the provider agrees to MCO's rate and adheres to MCO's quality requirements. To be considered a qualified provider, the provider must be in good standing with the Department's FFS Medical Program. MCO may establish quality standards in addition to those State and federal requirements and contract only with providers that meet such standards. Such standards must be approved by the Department, in writing, and MCOs may only terminate a contract of a provider based on failure to meet such standards if two criteria are met: a) such standards have been in effect for at minimum one (1) year, and b) providers are informed at the time such standards come into effect.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services

are provided by qualified providers.

i. Sub-Assurances:

- a. *Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

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

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

Performance Measure:

Number/percent of Supportive Living Program provider applicants that met certification requirements prior to enrollment with Medicaid. Numerator: Number of Supportive Living Program provider applicants that met certification requirements prior to enrollment with Medicaid. Denominator: Total number of Supportive Living Program provider applicants.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

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

	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: 	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number/percent of enrolled Supportive Living Program providers that continued to maintain certification annually. Numerator: Number of enrolled Supportive Living Program providers that maintain certification annually. Denominator: Total number of enrolled Supportive Living Program providers receiving annual certification reviews.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

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

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

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

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

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

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

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

Performance Measure:

Number/percent of MCOs that offered training as required by policy. Numerator: Number of MCOs that offered training as required by policy. Den: Total number of MCOs reviewed.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number/percent of certified dementia program Supportive Living Program providers that offered training as required by Department policy. Numerator: Number of certified dementia program Supportive Living Program providers that offered training as required by Dept. policy. Denominator: Total number of dementia program Supportive Living Program providers receiving annual certification reviews.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number/percent of certified Supportive Living Program providers that offered training as required by Department policy. Numerator: Number of Supportive Living Program providers that offered training as required by Department policy. Denominator: Total number of Supportive Living Program providers receiving annual certification reviews.

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

b. Methods for Remediation/Fixing Individual Problems

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

The State Medicaid agency (SMA) is responsible for ensuring individual problems are resolved.

Potential Supportive Living Program (SLP) providers found not to meet requirements for initial certification are given an opportunity to make changes that would allow them to be compliant. If program rule requirements are not met, the Department does not enter into a Medicaid provider agreement with the provider.

When SLP providers that are already certified and providing waiver services receive findings of non-compliance, a plan of correction (POC) must be developed to address the problem area(s). The POC must be submitted to the SMA within fourteen days of receipt of the findings and implemented within thirty days. SMA staff performs a follow-up on-site review to determine if remediation has occurred. If non-compliance is still identified, the SLP provider receives a form outlining the current non-compliance area(s) and is given another thirty days to correct. Continued non-compliance during a second onsite follow-up review by SMA staff results in sanctions, including but not limited to mandatory in-servicing for staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with relocation options, including transferring to another SLP provider. The same procedures are followed for the dementia program.

If an MCO is found not to have provided training as required, remediation would occur within 60 days in the form of training being completed. Upon receipt of findings of lack of training completion, the SMA directs the External Quality Review Organization (EQRO) to initiate a Corrective Action Plan (CAP) to the MCO, requiring remediation within 60 days. The EQRO requires the MCO to submit evidence of training, including but not limited to agendas, training materials, and attendance rosters. The EQRO maintains oversight of the MCO's response to ensure that training is provided within 60 days of the MCO's receipt of the CAP. The EQRO reviews the documentation to ensure compliance with SLP training requirements and submits the CAP findings to the SMA, including any outstanding issues that were not addressed. The SMA determines actions on non-remediated findings, which may include MCO removal of staff from SLP case management until training is completed or sanctions. The SMA directs the EQRO to continue follow-up with the MCO on non-remediated findings until the actions are complete, which is limited to 60 days from the date of the SMA action of non-remediated findings.

The SMA's contracts with MCOs include termination rights. If the MCO fails to perform to the SMA's satisfaction on any material requirement of the contract or if the MCO is in violation of a material provision of the contract, the SMA has the right to terminate the contract. The SMA provides a written notice to the MCO requesting that the breach or non-compliance be remediated within a timeframe determined by the SMA. The SMA allows at least 60 days for the MCO to come into compliance and if that does not occur, the SMA can terminate the contract.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">EQRO</div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

- No
- Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, [HCB Settings Waiver Transition Plan](#) for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Settings in this waiver will comply with federal HCBS requirements per Attachment #2 in this renewal application.

89 IL Adm in. Code, Section 146.210 outlines structural requirements for Supportive Living Program (SLP) providers that ensure a home-like setting for waiver participants. For instance, minimum square footage requirements for apartments ensure participants have comfortable living spaces. Each apartment must have a private bath, living, sleeping, cooking and dining areas. Additionally, each apartment must have a door that locks from the inside and individually controlled heating and cooling. Participants' kitchen areas must include a refrigerator, sink, stove or microwave for cooking and an area for dining. There must also be wiring for telephone and access to cable television or a master antenna. Participants are free to decorate their apartments to reflect their individual taste and style. Additionally, all residents have their own private apartment unless they choose to share a double occupancy apartment.

Common areas are also required in SLP settings to encourage and support participant socialization. Common areas may include private dining rooms, libraries, computer rooms, outside garden/patio areas, family rooms and chapels. Participant laundry rooms are required as well so that that participants may do their own laundry, if they choose. Common areas must be available for participants' use at any time.

Participants can come and go from their apartments and from the building. Note the dementia program has delayed egress (see below). Additionally, participants are allowed visitors of their choosing at any time, including those in the dementia program.

Access to the larger community is available in the SLP setting. Participants may have their own vehicles with which to access the community. SLP providers may have transportation available or transportation may be available via public transit, local senior or disability advocacy groups or a private transportation company. Shopping trips are arranged at least weekly. Other scheduled activities may include: musical events, religious services, educational opportunities, charity/volunteer opportunities, sporting events, shopping, restaurants, museum trips, scenic drives and outdoor activities. Waiver participants are encouraged to provide input regarding community activities based on their preferences. SLP provider staff also encourage individual community participation, such as volunteering or opportunities for learning. The required comprehensive assessment also includes a section to identify a person's individual interests. Residents are able to access the community and participate in any community activities/events they wish. Additionally, community members are invited into SLP settings. Medical professionals provide information on health and wellness. children's groups provide musical and social entertainment. Faith-based groups and musical entertainers are also common guests.

Opportunities for community involvement are communicated to participants both in writing through activity calendars and newsletters, as well as verbally by staff.

The SMA is responsible for identifying restrictive interventions. Oversight activities occur during on-site visits, including annual certification reviews, complaint investigations, scheduled technical assistance visits and unannounced monitoring visits.

During on-site annual certification reviews, SMA staff reviews participant records and also interviews a representative sample of participants. Participants are asked if they have been informed and are aware of their rights. They are also asked about their satisfaction with the care they receive and if they know to whom they may register complaints. Additionally, during the record review, SMA staff has the opportunity to identify the use of restrictive interventions.

The use of restrictive interventions can also be brought to the SMA's attention at any time via the toll-free complaint hotline, email or written correspondence. Anyone, including participants, their families and provider staff, may register a complaint. Furthermore, the State Long Term Care Ombudsman Program would inform the SMA if staff became aware of or suspected the use of restrictive interventions by a SLP provider. SMA staff must perform on-site investigations in response to complaints received.

SMA staff may conduct scheduled and unscheduled visits for the purposes of monitoring and providing technical assistance to Supportive Living Program (SLP) providers. These visits offer another opportunity for SMA staff to detect the use of restrictive interventions.

If an SLP provider was using restrictive interventions, the SMA would issue a finding of non-compliance. The SLP provider has 30 days to develop and implement a plan of correction from the date written notification of the non-compliance is issued. SMA staff performs an on-site follow-up review to verify the use of restrictive interventions is no longer being practiced. If non-compliance persists after a second follow-up review, the SMA could impose sanctions, including suspending or terminating the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff would assist waiver participants in identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a participant's health or safety was threatened by the use of restrictive interventions, the SMA could also issue a notice of immediate jeopardy. If a participant is at risk at the time of the on-site review, SMA staff remains at the SLP provider until the area of non-compliance associated with the immediate jeopardy has been abated. Immediate jeopardy also requires the SLP provider to submit and implement a plan of correction within ten days of receipt of the findings. SMA staff performs an on-site follow-up review to verify that remediation has occurred and that the SLP provider is in compliance with administrative rules. If non-compliance is identified, the SMA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants in identifying possible relocation options, including transferring to another SLP provider.

Dementia program participants' safety needs are met with a service intervention of alarmed, delayed exit doors. When the door's release bar is pushed, an alarm sounds. The door will open if the bar is pushed for several continuous seconds. Dementia participants have the freedom to move within the dementia care setting, including access to secured outdoor common space.

Participation in the dementia program is voluntary. The participant, his/her physician, family and dementia program staff collaborate to determine if the dementia program is a beneficial setting. The need for extra supervision is based on a participant's individual characteristics and needs for care and support. All dementia participants must have an elopement risk assessment completed prior to admission and quarterly thereafter by a registered nurse to determine if alarmed, delayed exit doors are a necessary safety intervention. If a participant is assessed to no longer require this intervention, SLP provider staff discusses a different community placement with the participant and his/her designated representative. SMA staff review elopement risk assessments during on-site certification reviews for all participants.

Dementia program participants are able to leave the dementia care setting at any time with staff, family or other designated individuals. SLP provider activities includes options both on-site and in the larger community. Dementia participants may also have visitors at any time. Visits by family and friends are encouraged and do not have to be prearranged with the SLP provider. SLP provider staff is available 24 hours per day to allow visitors access to the building.

SMA staff completes on-site annual certification reviews for the dementia program. SMA staff verifies that participants have been appropriately assessed for the needed safety intervention of alarmed, delayed exit doors. They also confirm assessments were timely, complete and accurate. Participant access to common areas is also verified. If program non-compliance is identified, the process outlined above for SLP providers is followed.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Individual Support Plan (ISP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the state
- Licensed practical or vocational nurse, acting within the scope of practice under state law
- Licensed physician (M.D. or D.O)
- Case Manager (qualifications specified in Appendix C-1/C-3)
- Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Fee for Service:

The SLP provider Registered Nurse (RN) is responsible for the development of the service plan. The RN must have an active nursing license in the State of Illinois.

Managed Care Enrollees:

The service plans for participants enrolled in managed care are completed by the Plans' case managers. Case managers receive a minimum of twenty (20) hours in-service training initially and annually. Case managers must be trained on topics specific to the Supportive Living Program waiver, including: resident rights; prevention and notification of abuse, neglect, and exploitation; behavioral interventions, techniques for working with the elderly and persons with disabilities; and disability sensitivity training.

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

b. Service Plan Development Safeguards. *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Participants (partic.) may choose among Supportive Living Program (SLP) providers (prov.). By selecting a SLP prov. and executing a resident contract (RC), the partic. accepts the services (svcs) that the SLP prov. is obligated to provide under the SLP. The RC must include information regarding the svcs. the partic. will receive from the SLP prov. that are covered under Medicaid (89 IL Adm Code (IAC), Chap. I, Section 146.240(b)(1)). A partic. is free to cancel a RC and transfer to another svc. prov. or choose to participate in another program at any time. The option to end the RC is included in the RC approved by the SMA.

Fee for Service:

The SLP prov. RN is responsible for the development and implementation of the person centered Plan (PCP) (89 IAC, Chap I, Section 146.245(d)). In addition to the PCP, an RN is responsible for the initial assessment, comprehensive resident assessment, and quarterly evaluations (89 IAC, Chap I, Sec. 146.245(b), (c) and (e)). Other nursing services include: medication set-up, administration and episodic and intermittent health promotion or disease prevention (89 IAC, Chap I, Sec. 146.230(b)(1-4)). For svcs. not provided by the waiver, such as physical therapy, a partic. may select the prov. of his/her choice. Additionally, SLP prov. are required to assist partic. with obtaining these svcs.(89 IAC, Chap I,(Sec. 146.250(e)(7)). The PCP must include coordination and inclusion of svcs. being delivered by an outside entity (89 IAC, Chap I, Sec. 146.245(d)), as well as any svcs. the partic. chooses to decline (89 IAC, Chap I, Sec. 146.250(e)(6)). Prov. cannot maintain SLP svcs. in combination with home health, home care, nursing home, hospital, residential care setting, congregate care setting or other type of residence or svc. agency unless those settings and svcs. are licensed, maintained and operated as separate and distinct entities (89 IAC, Chap I, Sec. 146.215(i)). The SMA verifies distinction of svcs. annually.

Partic. have the right and are strongly encouraged to participate in the development of their PCP (89 IAC, Chap I, Sec. 146.245(d) and 146.250(c)(16)). A designated representative (rep.) is involved at the request of the partic. and for partic. who are not able to be involved in the process due to their physical or cognitive status. Partic. may also include others in the PCP development (89 IAC, Chap I, Sec. 146.245(d)). Another right related to a partic.'s PCP is the option to refuse svcs., so long as others are not harmed by the refusal (89 IAC, Chap I, Sec. 146.250(e)(6)). The SLP prov. must explain the potential consequences to the partic. and/or his designated rep. and include the refusal in the PCP.

The SMA provides oversight of the PCP development process and delivery of svcs. by reviewing 100% of new partic.s' records and a rep. sample of continuing partic.s' records annually. PCPs are among the documents examined for timeliness, thoroughness and accuracy, as well as signatures of the RN and partic. A review of the partic.'s comprehensive assessment and their interview information is compared to the PCP to ensure all identified goals, preferences and needs are included. Additional documentation reviewed may include MD orders, nursing notes and medication orders and also partic. interview. The PCP must identify desired outcomes, partic. strengths and needs and steps to achieve desired outcomes, along with the person/staff/parties involved with the services and supports. Any svcs. refused by the partic. must also be noted. SMA staff interviews a rep. sample of partic. to verify their needs and preferences are being met.

These requirements also apply to partic. in the dementia program.

Managed Care:

MCO case managers do not provide direct waiver services. The MCOs' case manager completes an assessment to elicit comprehensive information from the partic. The assessment aids in the development of an overall health and support service plan that includes community health svcs., along with the waiver svcs. The components in the assessment used by the Plans include but are not limited to cognitive/emotional, ADLs, IADLs, behavioral health, medication, living supports, environmental conditions and health care information. Partic. and their designated representative are involved in the development of the service plan. The SLP provider RN also provides a copy of the comprehensive assessment and suggested waiver services, as discussed with the participant, to the case manager for review with the partic. and development of the PCP. Through the assessment and care planning process, the partic.'s goals and strengths and barriers to achieving these goals are identified. A copy of the PCP is given to the SLP provider.

These requirements also apply to partic. in the dementia program.

Fee for Service and Managed Care:

Partic. document their choice of provider at admission and annually thereafter. The SMA's and External Quality Review Organization's annual record reviews includes the review of written verification by the partic. re. choice of

provider.

These requirements also apply to partic. in the dementia program.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

A written resident contract/lease agreement that includes information regarding SLP services must be entered into by each waiver participant (89 IL Admin. Code, Chap I, Section 146.240(b)(1), "The resident contract shall include, but not be limited to, the following: Information regarding SLP services the resident will receive that are covered under the Medical Assistance Program"). This contract is signed prior to the time of admission, thus in advance of the development of the person-centered plan (PCP). The contract provides the participant and/or his/her representative with information regarding the services that are available through the SLP waiver. The SMA approves all resident contracts. This includes verifying available waiver services are identified in the contract. The contract must be in language and format understandable to the participant and his/her designated representative. The resident contract/lease agreement must also include a statement that the SLP provider will comply with all applicable federal, State and local laws and regulations (89 IL Admin. Code, Chap I, Section 146.240 (b)(4)).

A list of waiver participant rights, established by the SMA, must be provided to each participant with the resident contract (89 IL Admin. Code, Chap I, Section 146.240(b)(7). "The resident contract shall include, but not be limited to, the following: A list of the resident rights as stated in Section 146.250"). Among these is the right to all housing and services for which he or she has contracted and paid (89 IL Admin. Code, Chap I, Section 146.250(e)(2), "All housing and services for which he or she has contracted and paid"). Additionally, it is the right of a waiver participant to be involved in the development, implementation and review of his/her service plan (89 IL Admin. Code, Chap I, Section 146.250(e)(16) "Each resident shall have the right to: Participate in the development, implementation and review of his or her service plan").

SLP requirements also ensure that limited English speaking participants have the opportunity for meaningful communication that allows for equal access to benefits and services (89 IL Admin. Code, Chap I, Section 146.215(n), "The SLP shall ensure that limited English speaking residents have meaningful and equal access to benefits and services"). including information regarding available services, resident rights and development of their PCP. A copy of the PCP must be given to the participant, his/her designated representative and whomever else they choose, in a language and format that is understandable to them.

Participant rights established by the SMA give the participant the right to make and act upon decisions; participate in the development of the PCP; and designate or accept a representative to act on the participants' behalf. The 89 IL Admin. Code, Chap I, Section 146.250(e)(3) states, "Have his or her records kept confidential and released only with his or her consent or in accordance with applicable law". Additionally, the 89 IL Admin. Code, Chap I, Section 146.250(e)(15) requires a participant to "Make and act upon decisions (except those decision delegated to a legal guardian) so long as the health, safety and well-being of others are not endangered by his or her actions". The 89 IL Admin. Code, Chap I, Section 146.250(e)(16) states the participant shall, "Participate in the development, implementation and review of his or her service plans". Finally, the 89 IL Admin. Code, Chap I, Section 146.250(e)(19) ensures the right to, "Designate or accept a representative to act on his or her behalf".

Fee for Service:

Participants are encouraged to include individuals of their choice in the service planning process. SLP provider staff assists participants by scheduling PCP development meetings at a time and location convenient for the participant and others they designate. Input from participants regarding their goals, strengths and needs are among the things discussed. This includes both waiver and outside services. Refusal of services are also identified in the PCP. SLP provider staff reviews the possible consequences of the refusal with the participant prior to documenting in the PCP. The PCP form requires the participant's signature or his/her designated representative, if applicable, and may also be signed by others the participant chooses to involve in the development of the PCP. Participants are also informed of provider choice and receive contact information for the Department on Aging or Department of Human Services to receive referral information for other programs available to them, if requested. Choice of provider is documented during the PCP development process.

The requirements are the same for the dementia program.

Managed Care:

After the completion of the comprehensive assessment and the array of services have been presented to and discussed with the participant, the Plan's case manager, the participant and/or their representative(s) formulate a PCP that addresses their goals, strengths and barriers/risks in consideration of these goals, and the mutually agreed upon activities for achievement of these goals. As this is participant-centric, personal preferences are integral to the development of the PCP, such as cultural preferences and provider preferences for language and gender. The PCP includes the type, amount, frequency, and duration of waiver services, and includes services and supports not covered under the waiver, all related to

the needs and preferences expressed by the participant. The participant is in the center of the care/service planning process and may choose to include whomever they want in the development of the PCP. The participants have an active role in choosing the types of services and service providers to meet their needs. The case manager obtains the waiver participant's signature of agreement on the PCP.

The requirements are the same for the dementia program.

Appendix D: Participant-Centered Planning and Service Delivery

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

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The PCP capsulates the goals, needs and preferences (pref.) of each participant (partic.). Its development (dev.) is the result of collaboration by the partic., representative (rep.) and others of the partic.'s choosing, SLP provider (prov.) staff and MCO staff. Physicians and outside agencies providing non-waiver services (svcs.) may also be included. Each PCP team member provides input that assists with the dev. of the PCP. The PCP is always changing to reflect the current needs, goals and preferences. Waiver svcs. are provided by SLP prov. staff.

(a) Who develops the plan, who participates in the process and timing of the plan?

Fee for Svc:

The SLP prov.'s RN is responsible (resp.) for the partic.'s assessments (assess.) and assists the partic. with the dev. of the PCP. Individuals involved with the completion of the PCP are the partic. and people who have knowledge of the partic. and his/her needs and preferences. This includes family, friends, representatives (rep.), other individuals selected by the partic., healthcare prov. and SLP prov. staff.

The SLP nursing staff is resp. for the completion of PCPs. An initial PCP is required within 24 hours of admission (89 IL Adm. Code (IAC), Chap I, Sec. 146.245(b), "The SLF shall complete an initial assess. and svc. plan within 24 hours after move-in that identifies needs and potential immediate problems"). Initial plans are implemented during the period of time between admission and the dev. of the PCP. The PCP is due within 7-21 days of admission and includes a more in-depth discussion with the partic., a comprehensive (compr.) assess. and an observation period. Each PCP is individualized for the partic. The PCP is reviewed and updated at the request of the partic.. in conjunction with required evaluations (eval.) and as dictated by changes in a partic.'s condition, needs or preferences. The 89 IAC, Chap I, Sec. 146.245(d) states, "The svc. plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences". PCPs are dev. at a time and location convenient for the partic.. rep., others the partic. chooses to involve. The PCP form requires the partic.'s signature or rep., if applicable, and may also be signed by others the partic. chooses to involve in the dev. of the PCP.

The requirements (req.) are the same for the dementia program (prog.).

Managed Care:

The case manager completes a compr. assess. to identify the partic.'s needs and preferences. The SLP prov. RN also provides a copy of the SLP compr. assess. and suggested waiver svcs., as discussed with the partic., to the case manager for use with the dev. of the PCP. The partic., their rep. and anyone else they choose are involved in the dev. of the PCP. Through the assess. and care planning process, the partic.'s goals and strengths and barriers to achieving these goals are identified. PCPs are dev. at a time and location convenient for the partic., rep. and others the partic. chooses to involve. The PCP is due within 15 days of Plan notification of enrollment in the waiver and annually thereafter. It must be updated with any sig. change in condition or at the partic.'s request. A copy of the PCP is given to the SLP prov. The req. are the same for the dementia prog.

(b) The types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals and health status.

Fee for Svc:

Standardized Interview:

An interview administered by the SLP prov. that is geared toward the partic.'s svc. needs must be done at or before the time of move-in (89 IAC, Chap I, Sec. 146.245(a), "The SLF shall conduct a standardized interview geared toward the resident's svc. needs at or before the time of occupancy"). The req. is the same for the dementia prog. and those enrolled in an MCO.

Initial Resident Assess.:

An initial assess. of the partic. and an initial plan are completed within 24 hours after admission (89 IAC, Chap I, Sec. 146.245(b), "The SLF shall complete an initial assess. and svc. plan within 24 hours after admission that identifies needs and potential immediate problems"). Info. is obtained from the partic., rep. or whomever the partic. wishes to include, along with medical records. The compr. assess. described below may be used, or a version thereof may be dev. by the SLP prov. for use as the initial assess. The initial assess. is not intended to take the place of the compr. assess. required within 7-14 days of admission. These initial documents must be reviewed and signed by either a licensed practical nurse (LPN) or RN within 24 hours of admission. The LPN or RN reviews the initial assess. and other documentation, such as physician orders and medication lists, to verify the assess. adequately reflects the partic.'s needs and preferences. The req.

are the same for the dementia prog. and those enrolled in an MCO.

Compr. Assess.:

A compr. assess. tool required by the SMA is completed within 7-14 days after admission, annually and in response to a sig. change in condition. The compr. assess. is designed to capture the partic.'s strengths, needs, preferences, health status and risk factors. This tool assesses a partic.'s cognitive, communication, and vision patterns, mood and behavior patterns, physical functioning, ADLs and IADLs, continence, disease diagnosis, health conditions, oral/nutritional status, skin condition, activity and interest pursuit patterns and special treatments. It is completed through means of interview of the partic., rep. and others the partic. chooses to involve. SLP staff observation and the review of medical records are also included. Info. documented in the assess. and info. received from the partic. is used to develop the PCP. Completion of the assess. is the responsibility of the SLP prov. RN. The req. are the same for the dementia prog. and those enrolled in an MCO. For partic. enrolled in an MCO, a copy of the assess. is provided to the case manager.

Quarterly Eval.:

The quarterly eval. is completed within 92 days from the previous assess. This eval. must include info. regarding the partic.'s current status (89 IAC, Chap I, Sec. 146.245(e), "A quarterly eval. of the health and behavior status of each resident using a Dept. desig. form shall be completed"). As with the other assess. and the development of the PCP, the partic. and his/her desig. rep. participate in this eval.. The eval. form must be signed by the SLP prov. nurse and the partic. or desig. rep. Any changes noted in the quarterly eval. related to current waiver or non-waiver svcs., goals, strengths, needs or preferences are to be included in the PCP. The quarterly eval. is the responsibility of the SLP prov. RN. The req. are the same for the dementia prog. and those enrolled in an MCO. For partic. enrolled in an MCO, any potential changes to the PCP identified as a result of the quarterly assess. would be communicated to the case manager by the SLP prov. RN.

These required assess. also apply to the dementia prog.

Dementia Prog. Assess.:

The dementia prog. requires additional assess. specific to persons with cognition problems. These assess. are completed by the SLP prov. RN. If a dementia prog. partic. is enrolled in an MCO, copies of the assess. are provided to the case manager for use with the dev. of the PCP.

Elopement Risk Assess.:

An elopement risk assess. designated by the SMA must be completed for dementia prog. partic. prior to admission and quarterly thereafter. The purpose of the assess. is to determine if the partic. requires a safety intervention of alarmed, delayed exit doors. This assess. must be completed by an RN. The partic.'s need for this safety intervention must be included on the PCP.

Kitchen Appliance Assess.:

Prior to admission and quarterly thereafter, an assess. of the partic.'s ability to safely operate kitchen appliances must be completed. This assess. must be completed by an RN. The partic.'s need for a safety intervention as it applies to kitchen appliances must be included the PCP.

MOCA or SLUMS Assess.:

The Montreal Cognitive Assess. or the St. Louis University Mental Status assess. must be completed within 7-14 days of admission. This assess. must be completed by an RN.

Managed Care:

The MCOs' case management team completes an assess. to elicit compr. info. from the partic. The assess. aids in the dev. of an overall PCP that includes community health svcs., along with the waiver svcs. The components in the assess. used by the Plans include but are not limited to cognitive/emotional, ADLs, IADLs, behavioral health, medication, living supports, environmental conditions and health care info. The SLP prov. RN also provides a copy of the SLP compr. assess. and suggested waiver svcs., as discussed with the partic., to the case manager for use with the dev. of the PCP.

Plans identify the need for case management through a variety of tools that help identify risk level. Examples of some of the tools used for identifying risk include a health risk screening, predictive modeling and surveillance data. During the assess. process or during the PCP dev., and at any time potential risks arise due to a change in the partic.'s status or

preferences, Plans gather this information and stratify enrollees to determine the appropriate level of intervention by the case management prog.. Members are assigned low, moderate or high risk levels. The higher the risk category, the more intensive the care management provided.

Plans must identify and eval. risks associated with the SLP partic.'s care. Factors considered include the potential for deterioration of the member's health status; the member's ability to comprehend risk; caregiver qualifications; appropriateness of the residence for the member; and behavioral or other compliance risks. The Plans incorporates the results of the assess. of risks into the PCP. Plans analyze predictive-modeling reports and other surveillance data of members monthly to identify risk-level changes. As risk levels change, reassess. will be completed as necessary and PCPs updated. Plans are required to review PCPs of high-risk members at least every 30 days, and of moderate-risk members at least every 90 days. They conduct reassess. as necessary based upon such reviews. A copy of the PCP is given to the SLP provider.

At a minimum, the Plans conduct a health-risk reassess. annually for each member. In addition, Plans must conduct a face-to-face health-risk reassess. for members receiving SLP waiver services each time there is a sig. change in the member's condition or a member requests reassess.

These required assess. also apply to the dementia prog.

(c) How the participant is informed of the services that are available under the waiver;

Fee for Svc. & Managed Care:

The resident contract is required to include info. regarding the svcs. available to partic. under the waiver. The SLP prov. must ensure the contract is in a language appropriate for the partic. or their rep. (89 IAC, Chap. I, Sec. 146.240(f). "The SLF shall ensure that all SLF materials, including the resident contract, shall be in a language appropriate to the resident population"). The contract must also include a listing of resident rights for the SLP (89 IAC, Chap. I, Section 146.240(b)(7)). SLP prov. are required to submit to the SMA for approval, prior to use, copies of every type of resident contract, thus ensuring waiver svcs. and partic. rights are included in the contract (89 IAC, Chap I., Sec. 146.215(c)(3), "Submit for approval prior to use a model of every type of resident contract to be used by the SLF"). The contract must be signed by the partic. or rep. at or prior to occupancy. Partic. also receive a SMA SLP resident rights brochure at the time of admission and annually thereafter. The req. are the same for the dementia prog.

Managed Care:

Partic. are informed by the Plan of the covered waiver svcs. at the initial visit and annually thereafter.

The req. are the same for the dementia prog.

(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences

Fee for Svc.:

By combining info. gathered from req. assess., the partic. and others desig. by him/her, and medical documentation, the SLP RN is able to assist the partic. with the dev. and implementation of the PCP. Every svc. provided to the partic., whether supplied by the SLP prov. or an outside agency, must be included in the PCP. The PCP must also include needs, preferences and goals expressed by the partic. or his/her desig. rep.

The PCP must: (1) Capture what is important to the partic. Examples include: goals, personal interests, cultural and lifestyle considerations and svc. needs and preferences identified by the partic.; (2) Specify a desired outcome(s) for these interests, goals, svc., etc.; (3) Identify the partic.'s strengths as it relates to obtaining the desired outcome; (4) Outline the partic.'s needs, if any, for achieving or striving to achieve the desired outcome; (5) Steps identified by the partic. and PCP team to achieve the desired outcome, including specifying steps which the partic. will complete and those to be completed by the SLP prov. or other applicable party; and (6) Barriers to achievement of desired outcomes or risks, including education or information provided to the partic. regarding the barrier and/or risk.

The PCP process ensures the partic. is actively involved and driving the dev. of the plan. The process requires the identification of partic. goals, preferences and needs, timely assess. and the use of qualified staff to complete and monitor

the assess. process and assist with plan dev. and implementation. For fee for svc. partic., the SLP prov. RN is responsible for assisting the partic. with the dev. of the PCP.

The req. are the same for the dementia prog.

Managed Care:

Comprehensive assess. are dev. by the MCOs. The MCO contract specifies expectations for waiver clients, including content of and purposes for Enrollee Care Plans and HCBS Waiver service plans. Additionally, the SLP prov. RN shares a copy of the SLP comprehensive assess. and suggested waiver services, as discussed with the partic., for the case manager to use in the dev. of the PCP.

After the completion of the a comprehensive assess. and the array of svcs. have been presented to and discussed with the partic., the Plan's case manager, the partic. and/or their rep. formulate an individualized care plan that addresses their goals, strengths and barriers/risks in consideration of these goals, and the mutually agreed upon activities for achievement of these goals. The outcome is a PCP. As this is participant-centric, personal preferences are integral to the dev. of the svc. plan, such as cultural preferences and prov. preferences for language and gender. The svc. plan includes the type, amount, frequency, and duration of waiver services, and includes services and supports not covered under the waiver, all related to the needs and preferences expressed by the partic.

The req. are the same for the dementia prog.

(e) How waiver and other services are coordinated;

Fee for Svc.:

The PCP must include the coordination of waiver and non-waiver svcs. being delivered to a partic. by the SLP prov. or an outside entity (89 IAC, Chap 1, Section 146.245(d), "This includes coordination and inclusion of svcs. being delivered to a resident by an outside entity"). The coordination of waiver and non-waiver svcs. are accomplished in a variety of ways including, during the completion of required assess. and by communication at any time between the partic. and SLP prov. Whenever and however the info. is learned, it must be incorporated into the PCP.

Partic., desig. rep. and whomever else the partic. chooses receive a copy of the PCP in a language they can understand. Info. related to providing waiver svcs. and assisting the partic. with reaching desired outcomes is shared with relevant SLP prov. staff so they may implement the svcs. detailed in the plan according to the partic.'s needs and preferences. The SLP prov.'s RN and management staff are responsible for communicating with other staff regarding the implementation of the PCP, including the partic.'s choices and preferences. The SLP prov.'s RN is responsible for ensuring that the partic.'s PCP is implemented appropriately, including coordination with outside entities.

The req. are the same for the dementia prog.

Managed Care:

Svcs. are coordinated by the partic.'s assigned Plan case manager, who is responsible for the identification, authorization, and assignment to the responsible svc. prov. in coordination with and direction from the partic. and/or their rep. The SLP prov. receives a copy of the PCP.

The req. are the same for the dementia prog.

(f) How the plan development process provides for the assignment of responsibilities to implement and monitor the plan;

Fee for Service:

The PCP must identify who will assist and support the partic. with achieving their desired outcomes for waiver and non-waiver svcs. (89 IAC, Chap 1, Section 146.245(d)). "The svc. plan shall include...whether the svcs. will be provided by licensed or unlicensed staff"). During the implementation process of the PCP, the appropriate individuals are notified regarding their responsibilities in providing specific services and support to the partic. The PCP also includes the partic.'s strengths that will assist with achieving desired outcomes and the steps to achieve they have identified. The SLP prov.'s RN is responsible for assigning responsibilities to implement the PCP and to also monitor. PCPs are reviewed at least quarterly, or more often if a change in condition occurs or at the partic.'s requests.

The req. are the same for the dementia prog.

Managed Care:

The Plan case manager is responsible for the execution of the PCP, which includes monitoring the provision of waiver svcs. and risk mitigation strategies. The partic.'s role is clearly defined in the PCP, and the partic. is responsible for actively participating and providing feedback.

The req. are the same for the dementia prog.

(g) How and when the plan is updated, including when the participant's needs change.

Fee for Svc.:

Partic. may request a review of their PCP at any time. At a minimum, the PCP must be reviewed quarterly. If a partic. experiences a sig. change in condition, needs or preferences, the PCP must be updated at that time (89 IAC, Chap I, Section 146.245(d), "The svc. plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in the resident's needs or preferences"). PCPs must be completed at least annually.

The req. are the same for the dementia prog.

Managed Care:

For partic. enrolled in an MCO, the Plan case manager is the lead for waiver svc. planning. The partic.'s PCP dev. begins with a comprehensive assess. of the partic.'s health and supports, svc. needs, and their preferences and goals. The SLP prov. RN also provides a copy of the SLP comprehensive assess. and suggested waiver services, as discussed with the partic., to be used by the case manager in the dev. of the PCP. Based on the outcome of the assess., the case manager works with the partic. to dev. a PCP reflective of his/her goals, needs and choices. The partic.'s family and circle of support, if the partic. so chooses, and his/her legal rep. may be involved in every step of the assess. and planning process.

After each comprehensive assess. is completed, in which the member's current status and needs are identified; a new PCP is completed. During the assess., and as needed in-between assess., the case manager educates the partic. to call the case manager to request a change in the plan if the partic.'s situation or needs change in-between assess. The partic. is educated to notify the case manager any time there is a change in their living or medical situation that may affect their need for svcs. PCPs can be created or adjusted in-between assess. to meet the member's immediate needs. Whenever there is a sig. change svc. needs or functioning (for example, hospitalization sig. impacting the partic.'s level of functioning), a new assess. is to be completed and additional svcs. provided as needed.

The partic. is in the center of the PCP process. The case management staff completes a comprehensive assess. to identify the partic.'s strengths, needs, formal and informal supports based on information provided by the partic. or rep. The partic. have an active role in choosing the types of svcs. and svc. prov. to meet those needs. The case manager obtains the partic.'s signature of agreement on the PCP and offers a choice of prov. to fulfill the svcs.

The case manager is responsible for providing clear direction to the partic. regarding appeal rights whenever a reduction, termination, or suspension in svc(s). occurs. The appeal rights are summarized in the PCP that the partic. signs at the initial assess., and each reassess. thereafter. If the member appeals, the svcs. will remain intact until the appeal process is exhausted, including the State Fair Hearing. The member handbook/inserts that are provided to and reviewed with the partic. also provide info. on appeal rights and processes.

Timelines differ for completion of the health risk assess. for MCO enrollees only when a member becomes newly eligible for SLP waiver services. A health risk screening is completed within 60 days of enrollment, and the more in-depth health risk assess.t is completed within 90 days of enrollment. The assess. collects info. about the member's physical, psychological, and social health.

- For members already receiving SLP waiver svcs. on their effective enrollment date with the health plan: the health-risk assess. must be face-to-face and completed within 90 days.
- For members receiving SLP waiver svcs. and were enrolled in another health plan but transitioning to a new health plan: the health-risk assess. relating to those covered services must be face-to-face and completed within the first 90 days after the effective enrollment date.

- For members deemed newly eligible for the SLP waiver: the health-risk assess. must be face-to-face and completed within 15 days after the health plan is notified that the member is determined eligible for SLP waiver svcs.

All covered svcs. start immediately - the day the member enrolls with the health plan. For members deemed newly eligible for SLP waiver, the Plan has 15 days to complete a health-risk assess. The assess. must be face-to-face. SLP waiver svcs. then begin within those 15 days for the member.

For reassess., Plans analyze reports and data on a monthly basis to identify risk level changes. High risk members have PCPs updated every 30 days and moderate risk members have PCPs updated every 90 days. At a minimum, Plans shall conduct a health risk reassess. annually.

The same is true for the dementia prog.

Partic. are provided with appeal rights as follows:

- At the initial assess.;
- At subsequent assess.;
- When a partic. is denied access to svcs/;
- When svcs. are reduced and/or;
- When svcs. are terminated

As a condition of approval for the SLP waiver, a corrective action plan (CAP) addressing compliance with Person Centered Planning requirements in the Final Rule by requiring the person centered plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. The PCP CAP will be completed and fully implemented by December 31, 2018

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan. subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Potential risks are to be identified during the required formal assessment processes, during the ISP development and at any time potential risks arise due to a change in the participant's status or preferences. At the time a potential risk becomes known to the SLP provider, the risk must be discussed with the participant and/or the designated representative. The participant's physician, counselor, long term care ombudsman or other applicable party may also be included. The individual support plan (ISP) must identify the risk, document education of the risk to the participant and steps to overcome the risk. The ISP will identify the participant's role and which staff and/or party will be included in addressing the risk. Should the participant choose to refuse assistance in overcoming the risk, this will be documented on the ISP. For those enrolled in an MCO, the MCO will be notified.

Resident rights for the SLP allow the participant to refuse to participate in any service or activity once the potential consequences of such refusal have been explained to the participant or designated representative, so long as others are not harmed by the refusal (89 IL Admin. Code, Chap I, Section 146.250(e)(6). "Each resident shall have the right to refuse to receive or participate in any service or activity once the potential consequences of refusal have been explained to the resident and the resident's representative, if requested by the resident. Refusal shall be documented in the service plan and reviewed no less than quarterly"). The participant may also ask the State long term care ombudsman be present during these discussions. Participants can remain in the SLP provider building foregoing recommended or needed services from the SLP provider or available from others. However, should the participant forgo recommended services, an acknowledgement shall be made that the decision was made against the advice of the SLP provider or other appropriate entities. 89 IL Admin. Code, Chap I, Section 146.245(d) requires that these refused services be documented on the ISP (The service plan shall document any services recommended by the SLP that are refused by the resident").

SLP providers are required to have certified nurse aide staff on-site 24 hours per day to meet participants' scheduled and unscheduled needs. Licensed nursing staff is available on-site and on-call. If a staff person calls off or does not show up for work, on-call staff or other available staff would be required to fill in. The SMA monitors SLP provider staffing during annual on-site certification reviews for all SLP providers and in response to any complaints received. If non-compliance regarding staffing is identified, a finding of non-compliance is cited and the SLP provider must develop and implement a plan of correction within 30 days. In the case of insufficient staffing, the SMA requires the current staff schedule to be remediated while SMA staff is on-site. SMA staff completes an unannounced, on-site follow-up review to determine compliance. If the SLP provider is still out of compliance, another 30 days is allowed to remediate. If a second follow-up review continues to show non-compliance, sanctions are issued, up to and including provider termination. In this case, SMA staff would assist participants with relocation.

This process also applies to participants in the dementia program and those enrolled with an MCO.

Health Plans must offer care management to enrollees who receive covered services under the SLP waiver.

Health Plans identify the need for care management through a variety of tools and those tools help identify an enrollee's risk level. Examples of some of the tools used for identifying risk include a health risk screening, predictive modeling and surveillance data. During the assessment process or during the service plan development, and at any time potential risks arise due to a change in the participant's status or preferences, Health Plans gather this information and stratify enrollees to determine the appropriate level of intervention by the care management program.

Members are assigned low, moderate or high risk levels. SLP members can fall into any of these categories based on the tools and assessments mentioned above. The higher the risk category, the more intensive the care management provided.

Health Plans develop a comprehensive, person-centered individual plan of care (IPoC) for any member stratified as high-risk Level 3 (high risk) and for all enrollees in an HCBS waiver, including the SLP waiver. The IPoC must be developed within ninety (90) days after enrollment. This is developed in conjunction with the service plan developed by the SLP provider RN.

Health Plans must identify and evaluate risks associated with the SLP participant's care. Factors considered include the potential for deterioration of the member's health status, the member's ability to comprehend risk; caregiver qualifications, appropriateness of the residence for the member; and behavioral or other compliance risks. The Health Plans incorporate the results of the assessment of risks into the IPoC.

Health Plans analyze predictive-modeling reports and other surveillance data of all members monthly to identify risk-level changes. As risk levels change, reassessments will be completed as necessary and IPoCs updated. Health Plans are

required to review IPoCs of high-risk members at least every thirty days, and of moderate-risk members at least every ninety days. They conduct reassessments as necessary based upon such reviews.

At a minimum, the Health Plans conduct a health-risk reassessment annually for each member who has an IPoC. In addition, Health Plans must conduct a face-to-face health-risk reassessment for members receiving HCBS Waiver services including SLP waiver services each time there is a significant change in the member's condition or a member requests reassessment.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Waiver participants, including those in the dementia program, may choose among any certified SLP providers. Participants enrolled with an MCO may choose any certified SLP provider that contracts with the MCO. Information regarding these providers and services is available through a variety of resources including the Supportive Living Program website and the SMA directly. Additionally, the Illinois Department of Human Services, Family and Community Resource Center caseworkers, who are responsible for accepting Medicaid applications and determining eligibility, may make referrals. The Illinois Department on Aging and its contracted agencies, including Case Coordination Units that perform initial level of care assessments for residents in need of waiver services, may provide information regarding the SLP to potential participants and their families. The Department on Aging also operates help lines that provide referral information for elderly persons and their families. Additionally, State long term care ombudsmen are a resource for participants and supply information regarding providers, services and programs. Contact information for the long term care ombudsman must be posted in each SLP provider building.

For participants enrolled in an MCO, the Plan assists the participant in obtaining information and selecting from among qualified providers of waiver services. The Plans provide information about the available services and service providers to each participant and answer any questions that arise. The Plan assists the participant through the provider network supplying information relevant to the services selected by the member and available in the service area of their choosing. Participants always have first choice of the provider they select to meet their needs. Plans will support the participant in selecting a provider to meet their needs if the participant does not have a preferred provider identified. The Plan maintains a current list of qualified and contracted service providers which is made available to participants upon request. The participant is also educated that the Plans' provider list is available on the Plan's website.

By selecting a SLP provider and executing a resident contract, the participant accepts the services that the provider is obligated to provide under the SLP waiver. A participant is free to cancel a resident contract and transfer to another service provider or choose to participate in another program at any time. This is explained annually during the service planning meeting and referral contact information is provided to the participant, if requested. This applies to participants in the dementia program and those enrolled in an MCO as well.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Supportive Living Program (SLP) providers must develop individual support plans (ISP) in accordance with SMA requirements. (1) The participant, designated representative and any individuals the participant chooses must be involved in the development of the ISP to identify goals, desired outcomes, needs, strengths, preferences and lifestyle and cultural considerations. (2) The standardized comprehensive resident assessment completed by the SLP provider RN must be used to help identify participant strengths, needs and health care issues. (3) The ISP must be completed in a SMA designated format that identifies desired outcomes, participant strengths, needs and steps to achieve desired outcomes, along with any barriers and risks. The ISP must identify steps the participant will take to achieve desired outcomes, as well as services and supports supplied by the SLP provider or other applicable party.

The SMA conducts annual on-site certification reviews at all SLP providers. This includes a review of ISPs for a representative sample of all continuing waiver participants and 100% review of new waiver participants. SMA staff completes an in-depth record review that includes, but is not limited to the ISP, comprehensive assessment, quarterly evaluations, nursing notes, medication management service records, incident reports and physician orders. SMA staff also interview a representative sample of participants. This comprehensive review allows SMA staff to ascertain whether the ISP meets program requirements, that required waiver services are being provided and participant choices and preferences are included. SMA staff also determines if assessments and ISPs were completed timely and that any changes in condition and participant preferences were captured.

For the MCOs, the SMA selects a statistically valid sample for conducting onsite record reviews to assure compliance with federal assurances. The SMA uses a proportionate sampling methodology with 95% confidence level and a 5% margin of error for the MCOs. The methodology is adjusted when new MCOs are enrolled to ensure proportionate sampling across MCOs.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

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

Specify the other schedule:

Fee For Service:
PCPs are reviewed quarterly.

Managed Care:
PCPs are reviewed every twelve months or more frequently when necessary.

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

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

For participants enrolled in an MCO, the Plan is responsible for maintenance of service plan forms.

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The SMA is responsible for monitoring service plan implementation for fee for service participants. Participant health and welfare including those in the dementia program and enrolled in managed care is monitored by the SMA. On-site monitoring is performed annually and ongoing.

Fee for Service Participant Service Plan:

As part of the SMA's monitoring process, comprehensive record reviews are conducted annually for a representative sample of continuous waiver participants at all SLP providers and 100% of new waiver participants. This monitoring involves an in-depth record review that includes, but is not limited to: the person centered plan (PCP), comprehensive assessment, quarterly evaluations, medication management service records, incident reports and physician orders. SMA staff also meets in person with waiver participants in the representative sample and conducts a standardized interview that includes questions regarding services received and choices and preferences. The health and safety of participants is monitored by confirming all required and preferred services are included in the PCP, that risks are identified and mitigated, participants' physicians are notified of changes in condition and that required SMA reporting takes place as required by administrative rule.

SMA staff ensures participants' comprehensive assessments, which are used to assist with the development of the PCP, are completed within required timeframes, accurately reflect participant needs, strengths, health conditions and service provision and that any significant changes in condition are documented.

The PCP must include input from the participant and designated representative as identified by the inclusion of participant goals, preferences, strengths and declined services. The PCP must incorporate information from the comprehensive assessment, physician orders and any non-waiver services supplied by an outside provider. Nursing notes, progress notes, medication management service records and other documents are examined to substantiate that services are being provided.

SMA staff also document that the PCP is signed by the participant or designated representative, indicating their involvement with the development of the plan and their choice in selecting the SLP provider to supply required waiver services and/or assist with coordination of non-waiver services. In order to determine if the PCP has been developed accurately and is being fully implemented to meet all of the services needed and preferred by the participant, the SMA reviews the various documents noted above in the participant's record, in addition to participant interviews.

This thorough review allows SMA staff to ascertain whether or not all of the participant's needs and preferences and goals have been identified and are being met through services and supports outlined in the PCP. For instance, if a review of nursing notes indicates a participant has recently fallen several times, SMA staff expects the PCP to contain information related to fall-prevention services. Additionally, if the participant's record contains a physician order for physical therapy, SMA staff would verify these outside services were obtained and included in the PCP.

If a participant experienced a significant change in condition, SMA staff makes sure the change was noted in the PCP. They also verify that the participant's physician and designated representative were notified as required by administrative rule, or that the participant refused this notification.

More frequent monitoring of waiver participants' PCPs and health and safety may occur as the result of complaint investigations.

Administrative rule violations related to PCP implementation and the health and welfare of residents must be individually remediated and may be cited as findings of non-compliance by the SMA. The SLP provider is given a Response to On-Site Review Findings form which outlines the rule violations. The SLP provider must then develop and implement a plan of correction (POC) within 30 days of receipt of the findings. SMA staff performs an on-site follow-up review to ensure the POC has been implemented and has corrected the problem. If it has not, another 30 days is allowed and another follow-up review is conducted. If at this time the SLP provider still has not corrected the non-compliance, sanctions may be issued by the SMA, including termination of the Medicaid provider agreement.

These processes and requirements apply to the dementia program.

Managed Care:

The Plan's case manager is responsible for monitoring PCP implementation, including whether services and supports

meet the participant's needs.

The case manager works with the participant to identify the agreed upon services to include in the PCP and coordinates the service delivery process based on the participant's needs. Case managers also identify services, supports, or activity outside of the waiver benefit that may support the participant's PCP. In addition to being completed at the initial assessment and reassessment visits, the PCP is also reviewed in-between assessments, if there is a change in service needs.

Service provision and participant satisfaction are continually monitored at each assessment. During each reassessment visit, the case manager reviews the PCP to ensure that services are furnished in accordance with the PCP and that the services provided by the service provider are meeting the needs of the participant. A new PCP will be created at each reassessment to capture members review and agreement with the PCP even if needs or services have not changed. The need for any additional non-waiver based services is also discussed. The case manager provides on-going education to the participant about reporting any issues with the provision of services and their service providers. The participants are encouraged to call the case manager to assist in resolving issues identified by the participant.

The Plans have a process to implement a method of monitoring its case managers to include, but not be limited to conducting quarterly case file audits and quarterly reviews checking that service plans are completed with each assessment or in between assessments if members needs have changed, services listed on the PCP address members needs identified in the assessment and are comprehensive. The Plans have a process to compile reports of these monitoring activities to include an analysis of the data and a description of the continuous improvement strategies the case manager has taken to resolve identified issues. The Plans will provide the state the results of their discovery, remediation and any systems improvement activities during quarterly quality improvement meetings. Remediation will occur both on an individual and systemic basis.

Through its contract with the EQRO, the SMA assures that the Plans are complying with contract requirements and the waiver assurances for monitoring service plans. Participants enrolled in the Plan will be included in the overall representative sampling methodology used for evidentiary reporting of assurances.

The SMA selects a statistically valid sample for conducting onsite record reviews to assure compliance with federal assurances. The SMA uses a proportionate sampling methodology with a 95% confidence level and a 5% margin of error. The methodology will be adjusted when new MCOs are enrolled to ensure proportionate sampling across all operating entities.

b. Monitoring Safeguards. *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measures

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

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

Performance Measure:

Number/percent of waiver participants' and MCO waiver participants' service plans that address all of their assessed needs and personal goals. Numerator: Number of waiver participants' and MCO waiver participants' service plans that address all of their assessed needs and personal goals. Denominator: Total number of waiver participants' and MCO waiver participants' service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95%</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">EQRO</div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

#/% of dementia program waiver participants' and MCO dementia program waiver participant service plans that address all of their assessed needs and personal goals. Numerator: # of dementia program waiver participants' service plans that address all of their assessed needs and personal goals. Denominator: Total # of dementia program waiver participants' service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

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

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

Performance Measure:

Number/percent of dementia program waiver participants who have a service plan completed within 7 days of their comprehensive assessment. Numerator: Number of dementia program waiver participants with service plans completed within 7 days of their comprehensive assessment. Denominator: Total number of dementia program waiver participant service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

<input type="checkbox"/> Other Specify: 	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: 	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number/percent of waiver participants who have service plans completed within 7 days of their comprehensive assessment. Numerator: Number of waiver participants with service plans completed within 7 days of their comprehensive assessment. Denominator: Total number of waiver participant service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95%</div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: <input type="text"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number/percent of MCO waiver participant service plans that were signed and dated by the waiver participant and the case manager. Numerator: Number of MCO service plans that were signed and dated by the waiver participant and the case manager. Denominator: Total number of MCO service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <input type="text" value="95%"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

#/% of MCO dementia program waiver participant service plans that were signed and dated by the waiver participant and the case manager. Numerator: # of MCO dementia program service plans that were signed and dated by the participant and the case manager. Denominator: Total # of MCO dementia program waiver participant service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. **Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.**

Performance Measures

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

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

Performance Measure:

Number/percent of dementia program waiver participant service plans updated following an annual assessment. Numerator: Number of dementia program waiver participant service plans updated following an annual assessment. Denominator: Total number of dementia program waiver participant service plans reviewed that required an annual assessment.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

#/% of dementia prog. waiver partic. and MCO dementia prog. waiver partic. who received updates to service plans when partic. needs changed. Num: # of dementia prog. waiver partic. and MCO dementia prog. waiver partic. who received updates to svc. plans when partic. needs changed. Den: Total # of dementia prog. waiver partic. and MCO dementia prog. waiver partici. reviewed whose needs changed.

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

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">EQRO</div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

Performance Measure:

Number/percent of waiver participant service plans updated following an annual assessment. Numerator: Number of waiver participant service plans updated following an annual assessment. Denominator: Total number of waiver participant service plans reviewed that require an annual assessment.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95%</div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

Number/percent of waiver participants and MCO waiver participants who received updates to service plans when participant needs changed. Numerator: Number of waiver participants and MCO waiver participants who received updates to service plans when participant needs changed. Denominator: Total number of waiver participants and MCO waiver participants service plans reviewed whose needs changed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for	Frequency of data	Sampling Approach
-----------------------	-------------------	-------------------

data collection/generation (check each that applies):	collection/generation (check each that applies):	(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95%</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">EQRO</div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
EQRO	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:
 Number/percent of MCO waiver participants who have their service plan updated every 12 months. Numerator: MCO waiver participants who have their service plan updated every 12 months. Denominator: Total number of MCO waiver participant service plans reviewed.

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

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input checked="" type="checkbox"/> Other Specify: EQRO	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number/percent of MCO dementia care program waiver participants who have their service plan updated every 12 months. Numerator: MCO dementia care program waiver participants who have their service plan updated ever 12 months.
Denominator: Total number of MCO dementia care program waiver participant service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

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

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

Performance Measure:

Number/percent of waiver participants with written documentation of services provided according to the service plan. Numerator: Number of waiver participants with written documentation of services provided according to the service plan.
 Denominator: Total number of waiver participant records reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block; margin-top: 5px;">95%</div>
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number/percent of dementia program waiver participants with written documentation of services provided according to the service plan. Numerator: Number of dementia program waiver participants with written documentation of services provided according to the service plan. Denominator: Total number of dementia program waiver participant records reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="text"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

Number/percent of waiver participants with signatures on their service plan which attests to their choice of waiver services instead of institutional care. Numerator: Number of waiver participants with signatures on their service plan attesting their choice of waiver services. Denominator: Total number of waiver participant service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence

		Interval = <input type="text" value="95%"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number/percent of new waiver participants with a signed resident contract with the

SLP provider attesting their choice of provider. Numerator: Number of new waiver participants with a signed resident contract with the SLP provider attesting their choice of provider. Denominator: Total number of new waiver participants reviewed.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number/percent of dementia program waiver participants with signatures on their service plan which attests to their choice of waiver services instead of institutional care. Numerator: Number of dementia program waiver participants with signatures on their service plan attesting their choice of waiver services. Denomin: Total number of dementia program waiver participant service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

Number/percent of dementia program waiver participants with a signed resident contract with the SLP provider attesting their choice of provider. Numerator: Number of new dementia program waiver participants with a signed resident contract with the SLP provider attesting their choice of provider. Denominator: Total number of new dementia program waiver participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="text"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number/percent of MCO waiver participant service plans indicating the participant had choice between waiver service/institutional care and among providers.

Numerator: Number of MCO participant service plans indicating the participant had choice between waiver services/institutional care and among providers. Denominator: Total number of MCO participant service plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <input type="text" value="95%"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

#/% of MCO dementia care prog. waiver partic. svc. plans indicating the partic. had choice between waiver svcs./institutional care and among providers. Numerator: # of MCO dementia care prog. waiver partic. svc. plans indicating the partic. had choice between waiver svcs./institutional care and among providers. Denominator: Total # of MCO dementia care prog. waiver partic. svc. plans reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

The samples for the record reviews to verify participants' assessed needs and goals are included in the service plan will include two separate samples; one for all waiver participants and a second just for those enrolled in an MCO. The samples identified by the SMA for participants enrolled in an MCO for review by the EQRO will be proportionate among the Plans. These samples will be less than 100% review, but will have a 95% confidence level and a 5% margin of error. The random representative sample for all waiver participants used by SMA staff to review service plans will have a 95% confidence level and a +/-5% margin of error.

b. Methods for Remediation/Fixing Individual Problems

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

Incomplete Service Plans:
 If a participant's service plan does not address all of his/her assessed needs, the service plan must be revised. This remediation is verified by SMA staff. EQRO staff verifies remediation for service plans created by an MCO for participants enrolled in managed care.

Untimely Service Plans:
 When a participant does not have a current service plan, one must be developed and implemented. SMA staff verifies this remediation. For missing service plans and completed but untimely service plans, the SMA may issue findings of non-compliance. See the procedure outlined at the end of this section.

Service Plans Following Annual Assessment:
 If a waiver participant's service plan is not updated following the required annual assessment, this must occur once identified. SMA staff verify this remediation.

Significant Changes in Condition:
 If a waiver participant's service plan is not updated following a significant change in condition requiring new services, it would have to be updated once discovered. Additionally, the SLP provider would have to provide or arrange for any new services as the result of the change in condition. SMA staff verifies this remediation occurs.

Documentation of Services:
 If SMA staff cannot find evidence of services identified in the waiver participant's service plan being provided, the plan would have to be updated accurately to reflect the services that are needed. SMA staff verifies this remediation occurs and that the participant is receiving needed and preferred services.

Signed Service Plan:
 When a waiver participant's signature, or their designated representative's, is not included on the service plan, the plan must be reviewed with the waiver participant. After the review, the waiver participant is given the choice of accepting the waiver services outlined by signing the service plan. SMA staff verifies the signature is in place.

Signed Resident Contract:
 When a waiver participant's signature, or their designated representative's, is not on the resident contract, the contract must be reviewed with the participant. After the review, the participant is given the choice of accepting the provider for waiver services, which is indicated by signing the contract. SMA staff verifies the signature is in place.

In all cases of individual non-compliance outlined above, including in the dementia program, the SMA may issue findings of non-compliance to SLP providers for individual problems when discovered. The SLP provider is presented with a form outlining the areas of non-compliance. A plan of correction (POC) must be submitted to the SMA within fourteen days of receiving the findings. The POC must be implemented within 30 days. SMA staff performs an onsite follow-up review to determine if remediation has occurred. If non-compliance is still identified, the SLP provider receives another form outlining the current non-compliance areas and is given another 30 days to correct. Continued non-compliance during a second onsite follow-up review by SMA staff results in sanctions, including but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with relocation options, including transferring to another SLP provider. In the case of services not being provided, Medicaid reimbursement could be recovered.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">EQRO</div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

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

No

Yes

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

Appendix E: Participant Direction of Services

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

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The State of Illinois assures that each person whose request for assistance is denied is provided an opportunity for a fair hearing. Applicants and/or clients have the right to appeal any action, such as a denial or termination of services or reductions in service level. Illinois assures an opportunity for a fair hearing under 42 CFR Part 431, Subpart E, to waiver participants and potential waiver participants who are not given the choice of SLP services as an alternative to nursing facility services. This can occur as a result of not being determined eligible for Supportive Living Program (SLP) waiver services or receiving a notice of involuntary discharge from a SLP provider.

Waiver participants or their designated representative are informed of the appeal process in writing at the time of the denial of services. Furthermore, resident contracts for SLP providers must contain information regarding the involuntary discharge process, including the participant's right to appeal (89 IL Admin. Code, Subpart B, Section 146.240(b)(5), "The resident contract shall include, but not be limited to the following: The conditions under which the resident contract may be terminated by either party"). All resident contracts must be approved by the SMA, which insures appeal information is included.

Eligibility for SLP waiver services:

Prior to admission, all potential waiver participants, including those in the dementia program, must undergo an initial level of care assessment known as the Determination of Need (DON). Potential participants must meet a minimum score required for enrollment in the State's Medicaid-funded long term care program (either institutional or home and community-based services waivers), including the SLP. If a potential participant disagrees with the preadmission screening results, he may submit a request for an appeal to the SMA. An appeal form and self-addressed postage paid envelope is provided to the potential participant by the SLP provider. The SMA is responsible for maintaining the appeal documents and also reviews appeals.

Level of Care Determinations (LOCD) are performed annually for each waiver participant, including those in the dementia program, by the SMA. If a participant is found to no longer meet the required minimum level of care, a case action notice form is issued by the SMA. This form contains the reason(s) why the participant is no longer eligible for the program. Additionally, a notice of appeal form is supplied to the participant that contains a phone number for the SMA to request assistance with filing the appeal. The SMA is responsible for maintaining the case action notice form and also reviews appeals.

Additional assessments:

If a prospective resident or his/her representative disagrees with a mental health review completed by a qualified Department of Human Services (DHS) screening agent for the purpose of assessing persistent risks and needs to inform whether the person is appropriate for SLP placement, he/she may request an appeal through DHS. If the prospective resident or his/her representative does not agree with the response, the decision may be appealed to the SMA. Information regarding the appeal process is provided in writing to the prospective resident.

Involuntary Discharge From a SLP Provider:

SLP providers must provide written involuntary discharge notices to waiver participants (89 IL Admin. Code, Subpart B, Section 146.255 (b)), "The SLP shall provide a resident with a 30-day written notice of proposed involuntary discharge unless such a delay might jeopardize the health, safety, and well-being of the resident or others"). A 30-day notice is required, except in instances when participants are a danger to themselves or others, or when the participant's physical or mental health care needs require discharge sooner when health and safety are an issue (IL Admin. Code, Subpart B, Section 146.255 (b) and (c)), "The 30-day notice required under subsection (b) of this Section shall not apply in either of the following instances; however, a notice and right to appeal information must still be provided when an immediate discharge is required: 1) When an emergency discharge is mandated by the resident's health care or mental health needs as documented in the resident record. The SLP may consult with the attending physician for additional support on the emergency discharge. 2) When the discharge is mandated to ensure the physical safety of the resident and other residents as documented in the resident record"). A 30-day written notice of discharge can be issued by a SLP provider when: a participant breaches the resident contract, the provider has had its certification terminated, suspended, or not renewed by the SMA, the provider cannot meet the participant's needs with the required support services or when a participant has received proper notice of failure to pay the SLP provider for room and board and/or services. In the instance of non-payment, the participant has the right to make full payment up to the date that the discharge is to be made and then shall have the right to remain at the SLP residence.

The notice of involuntary discharge form must be completed by the SLP provider and given to the participant. The form includes the reason(s) for discharge, information for filing an appeal and a phone number for the SMA to request assistance with filing the appeal (89 IL Admin. Code, Subpart B, Section 146.255(b)). The SLP provider is required to supply a self addressed, stamped envelope with the appeal form (89 IL Admin. Code, Subpart B, Section 146.255(b)(4), "A hearing request form together with a postage paid, preaddressed envelope to the Department"). If an appeal is filed, the discharge is stayed until the hearing decision is rendered. The rule states that the participant may remain at the SLP residence until the 10th day after the receipt of the SMA's hearing decision, unless the participant is a danger to himself or others. The SLP provider is responsible for maintaining the notice of involuntary discharge form and right to appeal information. The SMA is responsible for conducting the hearing.

The Illinois Long Term Care Ombudsman program can assist participants with filing an appeal for any denial or reduction in services.

The above requirements apply to participants in the dementia program and enrolled in an MCO as well.

The MCO enrollee handbook, which all SLP participants receive, provides information on the MCO's Grievance and Appeals process and the State's Appeal and fair-hearing process, including how to register a Grievance or Appeal. Timeframes are included in this document. An SLP participant may appoint any authorized representative, including a guardian, caregiver, relative or provider to represent them throughout the Appeal process. The MCOs must provide a form and instructions on how a member may appoint a representative.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**
- Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- No. This Appendix does not apply**
- Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

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

The SMA is responsible for operating the Supportive Living Program (SLP) complaint system. The SLP complaint system is detailed in Section F-1. If a participant files a grievance or complaint associated with an issue related to a Fair Hearing matter, the participant is informed of the Fair Hearing process and SMA staff offers to assist the participant with filing an appeal. The SMA's procedures do not require a participant to file an informal grievance prior to exercising their right to appeal. An appeal can be requested by a participant/authorized representative for any notice of involuntary discharge. A participant does not need to file a grievance before starting this process.

Each MCO is required to establish and maintain a procedure for reviewing grievances (any expression of dissatisfaction about any matter other than an action or provider violation of administrative rule requirements) registered by enrollees. All grievances are registered initially with the MCO and may later be appealed to the Department through the Fair Hearing process. Enrollees must exhaust the MCO's grievance process before requesting a Fair Hearing.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Complaints about Supportive Living Program (SLP) providers may be registered by anyone. Complaints are received from waiver participants, friends and family, SLP provider employees and State long term care ombudsman. Individuals may register a complaint anonymously. The SMA receives complaints directly via a toll free telephone number, e-mail, written correspondence and in-person during on-site visits by SMA staff. There is no timeline for registering complaints. Complaints investigated by the SMA must be relevant to waiver services and program requirements. Additionally, all complaints are kept confidential.

When the SMA receives a complaint involving a possible administrative rule violation, a SLP Complaint Referral Notice form is completed and forwarded to regional SMA staff. This form contains specifics about the complaint, including waiver participants and staff involved, the nature of the complaint and date(s) of incident(s). For confidentiality, participant and staff names are not identified on the form itself, but are provided to regional SMA staff on an attached key. SMA staff must begin an investigation within seven days of receipt of the complaint. If a complaint involves immediate participant health and safety issues, regional staff are directed to investigate sooner. SMA employees are also mandated reporters. This status requires them to report suspected abuse or neglect of participants to local law enforcement.

Complaint investigations are performed on-site at the SLP residence. Investigations may involve interviews with waiver participants and staff, review of participant and employee records, a tour of the building and observation of staff providing services. Substantiated administrative rule violations are reported in writing to the SLP provider. The SLP provider must develop and implement a plan of correction within 30 days of receipt of the findings. SMA staff performs an on-site follow up review to verify remediation has occurred and that the SLP provider is in compliance with administrative rules. Persistent non-compliance in making corrections results in sanctions, including, but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants in identifying possible relocation options, including transferring to another SLP residence.

State long term care ombudsman also receive a copy of the SLP Complaint Referral Notice. Ombudsman can choose to attend the on-site the review with SMA staff, and/or perform their own investigation.

Concerns regarding denial of Medicaid eligibility and involuntary discharges are not handled by the complaint investigation process. In both of these instances, waiver participants are provided an opportunity to file a request for a Fair Hearing. The Fair Hearing process and complaint system are separate and independent.

When a participant is issued a notice of involuntary discharge or a notice that they are no longer eligible for the SLP waiver, a SMA designated appeal form is also provided to request a Fair Hearing. The appeal request form includes contact information for the SMA. SMA staff and long term care ombudsman are available to assist participants with completing the appeal request form and to answer any questions. Each SLP provider is also required to post SMA complaint hotline posters and LTC ombudsman posters on each floor in the building. Additionally, a copy of the SMA's Resident Rights brochure, which includes the toll-free complaint hotline number, must be provided to participants at the time of their initial and annual assessments.

The above also applies to participants in the dementia program and those enrolled in an MCO.

For participants enrolled in an MCO, applicable grievances shall be registered initially with the Plan and may later be appealed to the SMA. The Plan's procedures must (i) be submitted to the SMA in writing and approved in writing by the SMA; (ii) provide for prompt resolution and (iii) assure the participation of individuals with authority to require corrective action. The Plan must have a Grievance Committee for reviewing grievances registered by its enrollees, and enrollees must be represented on the Grievance Committee. At a minimum, the following elements must be included in the Grievance process:

- An informal system, available internally, to attempt to resolve all grievances;
- A formally structured grievance system that is compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 CFR Part 438 Subpart F to handle all grievances subject to the provisions of such sections of the Act and regulations (including, without limitation, procedures to ensure expedited decision making when an enrollee's health necessitates);
- Formally structured Grievance Committee that is available for enrollees whose grievances cannot be handled informally and are not appropriate for the procedures set up under the Managed Care Reform and Patients Rights Act. All enrollees must be informed that such a process exists. Grievances at this stage must be in writing and sent to the Grievance

Committee for review;

- The Grievance Committee must have at least one enrollee on the Committee. The SMA may require that one member of the Grievance Committee be a representative of the SMA;
- Final decisions under the Managed Care Reform and Patient Rights Act procedures and those of the Grievance Committee may be appealed by the enrollee to the SMA under its Fair Hearings system;
- A summary of all grievances heard by the Grievance Committee and by independent external reviewers and the responses and disposition of those matters must be submitted to the SMA quarterly; and
- An enrollee may appoint a guardian, caretaker relative, primary care provider, women's healthcare provider, or other physician treating the enrollee to represent the enrollee through the grievance process.

The State has provided that individuals must first avail themselves of the internal grievance and appeals process before accessing the Fair Hearings process. Enrollees are notified of this through the Enrollee Handbook, the Notice of Action, and any appeal letters. Plans also discuss the grievance and appeals process with the enrollee.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- No. This Appendix does not apply** *(do not complete Items b through e)*
If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The 89 IL Admin. Code, Subpart B, Section 146.295 defines an emergency as an event as the result of a mechanical failure or a natural force such as water, wind, fire or loss of electrical power, that poses a threat to the safety and welfare of residents, personnel and others present in the Supportive Living Program (SLP) residence. Additionally, 89 IL Admin. Code, Subpart B, Section 146.305(b) states the SLP provider manager or employee shall contact local law enforcement authorities immediately when suspected abuse, neglect or financial exploitation involving physical injury, sexual abuse, a crime or death occurs to a participant as the result of actions by a staff member, family member, visitor or another resident. All of these incidents must be reported to the SMA within 24 hours of occurrence (89 IL Admin. Code, Subpart B, 146.295(l), "Upon the occurrence of an emergency resulting from a mechanical failure or natural force requiring hospital service, police, fire department or coroner, the SLF manager or designee must provide a preliminary report to the Department by fax within 24 hours of the occurrence" and 146.305(e), "Upon the occurrence of suspect abuse, neglect or financial exploitation that results in contact with local law enforcement, the SLF manager or designee must provide a preliminary report to the Department by fax within 24 hours after the occurrence". When a participant is harmed during an emergency (as defined above), the SLP provider must inform the participant's physician and the designated representative (89 IL Admin. Code, Subpart B, Section 146.245(h), "The SLF manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, such reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLF staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities"). Except in life threatening situations, this notification must take place within 24-hours. Notification by phone is acceptable.

Reports for the incidents outlined above must identify the type of emergency, date(s) it occurred, any outside agencies involved, the names of participants involved, evacuation location(s), number of injuries or deaths, estimate of the extent of damage to the building, and the SLP provider's response to the emergency/incident. SMA staff reviews reports to ensure incidents were handled appropriately by SLP provider staff, that the appropriate agencies were contacted and to determine if any further review is required. Follow-up information, such as police reports, employee termination documentation or coroner reports are obtained as applicable.

Additionally, Illinois' Mandated Reporter Act (320 ILCS 20) requires healthcare workers, State long term care ombudsman, SLP staff and SMA staff to report suspected instances of abuse, neglect and financial exploitation to law enforcement authorities for further investigation. The SLP provider is expected to cooperate with any outside investigation conducted by law enforcement.

The above also applies to participants in the dementia program and those enrolled in an MCO.

For participants enrolled in an MCO, the Plans have processes and procedures in place to receive reports of critical incidents. The Plans comply with the Elder Abuse and Neglect Act (320 ILCS 20/1). The Plans have a formal process for reporting incidents that may indicate abuse, neglect or exploitation on an enrollee. The Plans must comply with the SMA's critical incident reporting requirement and notify the SMA of any critical incidents discovered, if this occurs prior to the SLP provider submitting a report to the Plan and SMA. If the Plan perceives an immediate threat to the participant's life or safety, the Plan will follow emergency procedures, which may include calling 911.

SLP providers are required to submit critical incident reports involving MCO enrollees to the Plans, as well as the SMA. All incidents will be reported to the compliance officer or designee and entered into the Plan's Critical incidents report database. If SMA staff perform an on-site review in response to the critical incident, a summary of the report will be shared with the Plans.

The Plans will provide participants, their family or representatives information about their rights and protections, including how they can safely report an event and receive the necessary intervention and support.

Also, the Plans will assure HCBS waiver agencies, vendors and workers (including case managers) are well informed of their responsibilities to identify and report all critical incidents. Responsibilities are also reinforced through periodic training.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities

when the participant may have experienced abuse, neglect or exploitation.

Supportive Living Providers (SLP) are required to include resident rights, as detailed in 89 IL Admin. Code, Subpart B, Section 146.250(e), in the resident contract (89 IL Admin. Code, Subpart B, Section 146.240(b)(7), "The resident contract shall include, but not be limited to, the following: A list of the resident rights as stated in Section 146.250"). Included in these rights are the right to be free from mental, emotional, social and physical abuse and neglect and exploitation. Another is the right to be treated at all times with courtesy, respect and full recognition of personal dignity and individuality. Every participant or his/her designated representative must review and sign the resident contract prior or at the time of admission. The SMA reviews SLP provider resident contracts to ensure resident rights information is included. Additionally, the SMA requires SLP providers to supply all participants with a "Hotline Information and Residents Rights" brochure at the time of admission. This brochure lists all of the rights participants have in the SLP and also offers the toll-free complaint hotline phone number. This brochure has been created and is distributed to SLP providers by the SMA. Resident rights information must also be provided annually at the time of the participant's required assessment. Additionally, SLP providers must display poster of the SMA's toll-free complaint hotline.

The SMA requires SLP providers to ensure limited English speaking participants have meaningful and equal access to services, including notification of their rights (89 IL Admin. Code, Subpart B, Section 146.215(n), "The SLF shall ensure that limited English speaking residents have meaningful and equal access to benefits and services"). This requirement can be met by having printed materials available in Braille and languages other than English, hiring bilingual staff or interpreters, and providing information to participants' representatives.

Additionally, SLP providers must encourage families of participants with impairments that limit the participant's decision making ability to arrange to have a responsible party or guardian represent the person's interests (89 IL Admin. Code, Subpart B, Section 146.215(o), "The SLF shall encourage families of residents with impairments that limit the resident's decision-making ability to arrange to have a responsible party or guardian represent the resident's interests").

During annual onsite reviews, SMA staff conduct interviews with waiver participants. A portion of the interview determines if the participant is aware of his/her rights. If a participant is not familiar or does not remember his/her rights, SMA provide them with a copy of the Hotline Information and Resident Rights brochure.

The State Long Term Care Ombudsman Program also distributes printed participant rights information. Additionally, contact information for registering complaints to the ombudsman is also provided.

The above also applies to participants in the dementia program and those enrolled in an MCO.

For participants enrolled in an MCO, the Plan shall train all of the Plan's employees, affiliated providers, affiliates and subcontractors to recognize potential concerns related to abuse and neglect, and on their responsibility to report suspected or alleged abuse or neglect. The Plans' employees who in good faith report suspicious or alleged abuse or neglect shall not be subjected to any adverse action from the Plans, its affiliated providers, affiliates or subcontractors.

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

The SMA receives critical incident reports. Participant abuse and neglect, serious injuries that require medical intervention and/or result in hospitalization, criminal victimization, death (other than by natural causes), financial exploitation and other incidents or events that involve harm or risk of harm to a participant are reported by SLP providers to the SMA (89 IL Admin. Code, Subpart B, Section 146.295(l), "Upon the occurrence of an emergency resulting from a mechanical failure or natural force requiring hospital service, police, fire department or coroner, the SLF manager or designee must provide a preliminary report to the Department within 24 hours after the occurrence. This includes, but is not limited to, loss of electrical power in excess of an hour, physical injury suffered by residents during a mechanical failure or force of nature, evacuation of residents for any reason, and fire alarm activation that results in an on-site response by the local fire department. It does not include fire department response that is the result of resident cooking mishaps that only cause minimal smoke limited to a resident's apartment or false alarms, as determined by the local fire department" and 146.305(e), "Upon the occurrence of suspect abuse, neglect or financial exploitation that results in contact with local law enforcement, the SLF manager or designee must provide a preliminary report to the Department by fax within 24 hours after the occurrence. This includes, but is not limited to, suspected abuse of any nature, allegations of theft, elopement of residents or missing residents, and any crime that occurs on facility property". An incident report must be submitted to the SMA within 24 hours of the occurrence.

The SMA reviews incident reports and determines if further follow-up is required according to established procedures. All follow-up is conducted by the SMA. Follow-up may be determined to be necessary by the SMA if a SLP provider did not notify the appropriate entities, such as police, physician or the participant's emergency contact. A follow-up investigation is required in the case of a serious incident, such as a fire. On-site reviews are also conducted in response to extended utility outages to verify that participants are safe and their needs are being met. The SMA will also investigate if incidents occur repeatedly or show a pattern.

The need for a follow-up review for critical incidents is determined based on the severity of the incident and the impact on participants, particularly their health and safety. SMA procedure requires on-site follow-up for incident reports impacting resident health and safety. Examples include extended power outages lasting more than 48 hours, physical damage to a SLP residence as the result of weather, fire or physical plant malfunction and also resident injury or death resulting from an emergency, such as a fire.

Regional SMA staff conduct the on-site review within the next working day of being notified by supervisory SMA staff, or sooner if instructed. The review process includes examination of the physical structure of the SLP residence, interviews with participants and staff, participant and staff record reviews and also outside reports related to the incident, such as police reports. A preliminary report is submitted the day of the on-site review to SMA supervisory staff so that participant health and safety can be confirmed. A formal written report must be submitted within two working days of the on-site review.

If the SLP provider is determined to be out of compliance with regulations, the SMA issues findings of non-compliance. The SLP provider is presented the findings in writing. A plan of correction must be submitted to the SMA within fourteen days of receiving the findings of non-compliance. The plan must be implemented within thirty days. SMA staff performs an on-site follow-up review to determine compliance and remediation. Persistent non-compliance in making corrections results in sanctions including, but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff would assist participants with relocation, including transfer to another SLP residence.

Additionally, if participants' current health or safety were threatened as the result of the SLP provider's response to the critical incident, the SMA would issue an immediate jeopardy. Immediate jeopardy results in SMA staff staying on-site at the SLP provider residence until the areas of non-compliance involving immediate health and safety have been abated. Immediate jeopardy also requires the SLP provider to submit and implement a plan of correction within ten days. SMA staff performs an on-site follow-up review to determine if remediation has occurred. If continued non-compliance exists, the SMA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff would assist waiver participants with relocation, including transferring to another SLP residence.

Critical incident reports are also tracked by the SMA. Information captured in the tracking report includes: participant names, SLP provider names, type of incident, timeliness of submission, provider response to the incident and the outcome.

Participants and their families are able to obtain information related to on-site reviews of critical incident reports by

contacting the SMA in writing or by phone. A copy of the written report for the on-site follow-up review is available through a Freedom of Information Act (FOIA) request. Protected health information is redacted from FOIA responses as applicable. SMA legal staff reviews all requests from participants or families and FOIA responses to verify compliance with HIPAA.

The above applies to participants in the dementia program and those enrolled in an MCO.

For participants enrolled in an MCO, the Plans will have similar processes and procedures in place to receive reports of critical incidents. Critical events and incidents must be reported and identified issues routed to the appropriate department within the Plan and when indicated to the investigating authority described above. The procedures will include processes for ensuring participant safety while the State authority conducts its investigation.

The State is responsible for the review and response of all critical events or incidents involving SLP waiver participants. MCOs are directed to contact the State if they become aware of a crime, abuse neglect or exploitation of a participant.

MCOs are required to comply with all health, safety and welfare monitoring and reporting required by State and federal statute or regulation, or that is otherwise a condition for a HCBS Waiver. MCOs must identify, address, and seek to prevent the occurrence of Abuse, Neglect and Exploitation. MCOs are required to educate Providers, Members, and Family Members about the signs of Abuse, Neglect, and Exploitation, and what to do if they suspect Abuse, Neglect or Exploitation. Training sessions must include general indicators of Abuse, Neglect, or Exploitation, and the timeframe requirements for reporting suspected Critical Incidents. MCOs must have processes in place to receive these reports. MCOs are expected to maintain an internal reporting system for tracking the reporting and responding to critical incidents, and for analyzing the event to determine whether individual or systemic changes are needed. MCOs are then required to complete a monthly Critical Incident report, and SLP residents are reported and tracked separately, as are other HCBS waiver members.

MCOs comply with the statutes and regulations listed below and any other similar or related applicable federal or State laws.

The Department of Human Services Act (20 ILCS 1305/1-1 et seq.),

The Abuse of Adults with Disabilities Intervention Act (20 ILCS 2435/1 et seq.),

The Elder Abuse and Neglect Act (320 ILCS 20/1 et seq.),

The Abused and Neglected Child Reporting Act (325 ILCS 5/1 et seq.)

MCOs are mandated reporters. If an MCO perceives an immediate threat to the member's life or safety, they should follow emergency procedures, which may include calling 911.

MCOs must have processes and procedures in place to receive reports of Critical Incidents. Critical events and incidents must be reported, and issues that are identified must be routed to the appropriate department within MCO and, when required or otherwise appropriate, to the investigating authority, including the SMA for SLP waiver participants.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The SMA is responsible for overseeing critical incident reports for the Supportive Living Program (SLP). All written incident reports submitted by SLP providers are entered into a tracking log report on an ongoing basis as they are received. The log captures information including: provider name, type of incident, participant names, provider response, timeliness of submission and outcomes.

The incident report log is reviewed on a continuous basis so that any issues such as timeliness, notification of local law enforcement or provider response are addressed. Patterns or trends identified for a particular provider or type of incident can be addressed in this way. Problems identified statewide or in a certain geographic area are responded to by issuing clarifications via a formal provider notice to all SLP providers and/or by offering provider training. Patterns and trends seen within a specific provider result in the SMA issuing findings of non-compliance and/or supplying technical assistance and clarifications to the provider. In the case of findings, an SLP provider would be required to develop and implement a plan of correction within thirty days of receipt of the findings. SMA staff performs an on-site follow-up review to verify remediation has occurred and to determine compliance with administrative rules.

The review of required critical incident reports is also done on an annual and ongoing basis during on-site annual certification reviews and complaint investigations. While on-site, SMA staff review participant and provider documentation to confirm that the SLP provider submitted critical incident reports as required. These procedures also apply to the dementia program and participants enrolled in an MCO.

In addition, for participants enrolled in a an MCO, the Plans maintain an internal reporting system for tracking the reporting and response to critical incidents and analysis of the event to determine whether individual or systemic changes are needed. Critical incident reporting will be included in the reporting requirements to the SMA. The SMA monitors both compliance of performance measures and timeliness of remediation for those waiver participants enrolled in an MCO.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. **Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The SMA is responsible for identifying the use of restraints. Oversight activities occur during on-site reviews, including annual certification reviews, complaint investigations and technical assistance visits.

During annual on-site certification reviews, SMA staff reviews participant records and also interview and inspect the apartments of a representative sample of participants. Participants are asked if they have been informed and are aware of their rights. This includes the right to be free of restraints. Participants are also questioned about their satisfaction with the care they receive and if they know to whom they may register complaints. Additionally, during the apartment inspection process, SMA staff has the opportunity to see any physical restraints.

The use of restraints is reported to the SMA via the toll-free complaint hotline, e-mail or written correspondence. Anyone, including participants, their families and provider staff, can register a complaint. SMA staff must perform on-site investigations in response to complaints received.

SMA staff conduct scheduled and unscheduled visits for the purposes of monitoring and providing technical assistance to Supportive Living Program (SLP) providers. These visits offer another opportunity for SMA staff to detect the use of restraints. Furthermore, the State Long Term Care Ombudsman Program informs the SMA if staff became aware of or suspect the use of restraints by an SLP provider.

If an SLP provider was using restraints with participants, the SMA would issue a finding of non-compliance. The SLP provider has 30 days to develop and implement a plan of correction from the date written notification of the non-compliance is provided. SMA staff performs an on-site follow-up review to verify the use of restraints was no longer being practiced. If non-compliance persists after a second follow-up review, the SMA implements sanctions, up to and including suspending or terminating the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a participant's health or safety was threatened by the use of restraints, the SMA would issue a notice of immediate jeopardy. If a participant is at risk at the time of the on-site review, SMA staff remains at the SLP provider until the area of non-compliance associated with the immediate jeopardy has been abated. Immediate jeopardy also requires the SLP provider to submit and implement a plan of correction within ten days of receipt of the findings. SMA staff performs an on-site follow-up review to verify that remediation has occurred and that the SLP provider is in compliance with administrative rules. If continued problems exist, the SMA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

These procedures apply to the dementia program and participants enrolled in an MCO.

Additionally, the MCO can detect the use of restraints through face-to-face visits, routine contacts with participants and possibly through complaint or incident reporting. If the Plans identify or learn of the use of restraints, it is reported as a critical incident and reported to the investigation authorities as indicated. In this instance, the Plan will be responsible for overseeing the waiver participant and assuring their health, safety and welfare.

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

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. (Select one):

- The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The SMA is responsible for identifying restrictive interventions. Oversight activities occur during on-site visits, including annual certification reviews, complaint investigations, scheduled technical assistance visits and unannounced monitoring visits.

During on-site annual certification reviews, SMA staff reviews participant records and also interviews a representative sample of participants. Participants are asked if they have been informed and are aware of their rights. They are also asked about their satisfaction with the care they receive and if they know to whom they may register complaints. Additionally, during the record review, SMA staff has the opportunity to identify the use of restrictive interventions.

The use of restrictive interventions is reported to the SMA via the toll-free complaint hotline, email or written correspondence. Anyone, including participants, their families and provider staff, can register a complaint. Furthermore, the State Long Term Care Ombudsman Program informs the SMA if staff became aware of or suspect the use of restrictive interventions by a SLP provider. SMA staff must perform on-site investigations in response to complaints received.

SMA staff conduct scheduled and unscheduled visits for the purposes of monitoring and providing technical assistance to Supportive Living Program (SLP) providers. These visits offer another opportunity for SMA staff to detect the use of restrictive interventions.

If an SLP provider was using restrictive interventions, the SMA would issue a finding of non-compliance. The SLP provider has 30 days to develop and implement a plan of correction from the date written notification of the non-compliance is issued. SMA staff performs an on-site follow-up review to verify the use of restrictive interventions is no longer being practiced. Follow-up reviews are unscheduled. If non-compliance persists after a second follow-up review, the SMA would impose sanctions, up to and including suspending or terminating the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a participant's health or safety was threatened by the use of restrictive interventions, the SMA would issue a notice of immediate jeopardy. If a participant is at risk at the time of the on-site review, SMA staff remains at the SLP provider until the area of non-compliance associated with the immediate jeopardy has been abated. Immediate jeopardy also requires the SLP provider to submit and implement a plan of correction within ten days of receipt of the findings. SMA staff performs an on-site follow-up review to verify that remediation has occurred and that the SLP provider is in compliance with administrative rules. If non-compliance is identified, the SMA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

Dementia program participants' safety needs are met with a service intervention of alarmed, delayed exit doors. When the door's release bar is pushed, an alarm sounds. The door will open if the bar is pushed for several continuous seconds. Dementia participants have the freedom to move within the dementia care setting, including access to secured outdoor common space.

Participation in the dementia program is voluntary. The participant, his/her physician, family and dementia program staff collaborate to determine if the dementia program is a beneficial setting. The need for extra supervision is based on a participant's individual characteristics and needs for care and support. All dementia participants must have an elopement risk assessment completed prior to admission and quarterly thereafter by a registered nurse to determine if alarmed, delayed exit doors are a necessary safety intervention. If a participant is assessed to no longer require this intervention, SLP provider staff discusses a different community placement with the participant and his/her designated representative. SMA staff review elopement risk assessments during on-site certification reviews for all participants.

Dementia program participants are able to leave the dementia care setting at any time with staff, family or other designated individuals. SLP provider activities includes options both on-site and in the larger community. Dementia participants may also have visitors at any time. Visits by family and friends are encouraged and do not have to be prearranged with the SLP provider. SLP provider staff is available 24 hours per day to allow visitors access to the building.

SMA staff completes on-site annual certification reviews for the dementia program. SMA staff verifies that participants have been appropriately assessed for the needed safety intervention of alarmed, delayed exit doors. They also confirm assessments were timely, complete and accurate. Participant access to common areas is also verified. If program non-compliance is identified, the process outlined above for SLP providers is followed.

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

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

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

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The SMA is responsible for identifying the use of seclusion. Oversight activities occur during on-site reviews, including annual certification reviews, complaint investigations, scheduled technical assistance and unannounced monitoring visits.

During annual on-site certification reviews, SMA staff reviews participant records and also interview and inspect the apartments of a representative sample of participants. Participants are asked if they have been informed and are aware of their rights. Participants are also questioned about their satisfaction with the care they receive and if they know to whom they may register complaints. Additionally, during the apartment inspection process, SMA staff has the opportunity to verify the participant is not in seclusion.

The use of seclusion is reported to the SMA via the toll-free complaint hotline, e-mail or written correspondence. Anyone, including participants, their families and provider staff, can register a complaint. SMA staff must perform on-site investigations in response to complaints received.

SMA staff conducts scheduled and unscheduled visits for the purposes of monitoring and providing technical assistance to Supportive Living Program (SLP) providers. These visits offer another opportunity for SMA staff to detect the use of seclusion. Furthermore, the State Long Term Care Ombudsman Program informs the SMA if staff became aware of or suspect the use of seclusion by an SLP provider.

If an SLP provider was found to be using seclusion with participants, the SMA would issue a finding of non-compliance. The SLP provider has 30 days to develop and implement a plan of correction from the date written notification of the non-compliance is provided. SMA staff performs an on-site follow-up review to verify the use of seclusion was no longer being practiced. If non-compliance persists after a second follow-up review, the SMA issues a sanction, up to and including suspension or termination the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a participant's health or safety was threatened by the use of seclusion, the SMA would issue a notice of immediate jeopardy. If a participant is at risk at the time of the on-site review, SMA staff remains at the SLP provider until the area of non-compliance associated with the immediate jeopardy has been abated. Immediate jeopardy also requires the SLP provider to submit and implement a plan of correction within ten days of receipt of the findings. SMA staff performs an on-site follow-up review to verify that remediation has occurred and that the SLP provider is in compliance with administrative rules. If continued problems exist, the SMA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

These procedures apply to the dementia program and participants enrolled in an MCO.

Additionally, the MCO can detect the use of seclusion through face-to-face visits, routine contacts with participants and possibly through complaint or incident reporting. If the Plans identify or learn of the use of seclusion, it is reported as a critical incident and reported to the investigation authorities as indicated. In this instance, the Plan will be responsible for overseeing the waiver participant and assuring their health, safety and welfare.

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

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

--

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)
- Yes. This Appendix applies** (complete the remaining items)

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Supportive Living Program (SLP) providers are responsible for ongoing monitoring of medication regimens for participants who choose to receive medication management services.

Information regarding participant medication orders is obtained at the time of the initial assessment, which is conducted within 24 hours of admission. The initial assessment should include a participant's medications, dosage, frequency and any assistance they require. This information is captured again during the comprehensive assessment completed within seven to fourteen days after admission. After the comprehensive assessment, medication regimens are reviewed and updated as needed after physician visits, hospitalizations or a change in a participant's condition. At a minimum, a participant's medication regimen must be assessed on a quarterly basis during required reviews. A licensed nurse is responsible for these reviews.

As part of the comprehensive assessment, a participant's ability to safely manage his/her own medication is examined. If a participant requires assistance, either in the form of medication set up, reminders, cuing for self-administration or administration, this is included in the service plan.

Additionally, a SMA form must be completed for medication errors identified by the SLP provider. SLP provider staff is responsible for completing this form, which includes a summary of the error, information regarding the notification of the participant's physician and a plan of correction. The same process for medication errors is required for dementia program participants and those enrolled in an MCO. For participants enrolled in an MCO, the SLP provider must notify the Plans of medication errors.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The SMA is responsible for monitoring medication management services provided to waiver participants by Supportive Living Program (SLP) providers. Records of waiver participants are reviewed extensively during on-site annual certification reviews. This includes examining comprehensive assessments, service plans, physician orders and medication management service records. SMA staff also observe the delivery of medication management services by SLP provider staff.

During the record review, SMA staff makes sure the participant's assessment corresponds with the service plan and the correct medication management service is identified. SMA staff also verifies that service plans are implemented and that participants receive services contained in the plan. Medication management service records are reviewed to verify required information is included, such as staff initials/signatures indicating the service was provided. Additionally, Medication Error Report forms are reviewed by SMA staff to verify they were completed as required, physician notification occurred and a plan of correction to prevent errors in the future was included.

If SMA staff discovers medication errors and/or physician's orders are not followed in regards to medication management services, findings of non-compliance would be issued. The SLP provider is required to develop and implement a plan of correction within thirty days of receiving written notice of the findings. SMA staff performs an on-site follow-up review to verify remediation has occurred and the provider is in compliance with administrative rules. Continued non-compliance can result in sanctions, including, but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a participant's current health or safety were threatened as the result of a medication management services not being provided appropriately, the SMA would issue a notice of immediate jeopardy. If the participant is at-risk at the time of the on-site review, SMA staff remains at the SLP provider residence until the immediate jeopardy has been abated. Immediate jeopardy requires the SLP provider to develop and implement a plan of correction within ten days. SMA staff perform an on-site follow up review to determine that remediation has occurred and the provider is in compliance with administrative rules. If continued non-compliance exists, the SMA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

The same procedures apply for the dementia program and participants enrolled in an MCO.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- Not applicable. *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*

- ii. **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Supportive Living Program (SLP) providers are required to provide medication management services. Depending upon participant needs and preferences, SLP staff offers a spectrum of medication management services. Among these are: medication set-up, verbal reminders, assistance with self-administration and medication administration (89 IL Admin. Code, Subpart B, Section 146.230(b)(2-3)), "When a resident is unable to administer his or her own medications, a licensed nurse shall administer the medications", "Nursing services shall include medication set-up (such as preparing weekly pill caddies with that week's medication" and (d), "medication Administration, Oversight and Assistance in Self-Administration").

As provided in the Nurse Practice Act (225 ILCS 65), only licensed nursing staff (registered or licensed practical nurse) may set-up medications or administer medications. Certified nursing assistants (CNA) are allowed to perform verbal medication reminders, hand participants their set-up medication from where it is stored and open medication containers.

SLP provider staff must document medication management services including the date, time, and staff signature/initials.

iii. **Medication Error Reporting.** *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**

Complete the following three items:

- (a) Specify state agency (or agencies) to which errors are reported:

All medication errors that occur for participants receiving medication management services from the Supportive Living Program (SLP) provider are required to be recorded on a Medication Error Report form. Medication errors that result in adverse reaction requiring hospitalization must be reported on the required form to the SMA within 24 hours. All other errors are recorded on the Medication Error Report form and made available to the SMA at its request. The form includes the name of the participant involved, the medication(s) and the type of error (i.e. time, dosage, etc.) and any adverse reaction observed. Additionally, the SLP provider must document that the physician and emergency contact were notified and include information regarding any instructions provided by the physician. Finally, the SLP provider must implement a plan of correction to prevent additional errors. These requirements also apply to the dementia program and participants enrolled in an MCO. While MCOs collect data on medication errors for SLP participants, the SMA is responsible for the review and response to medication error reporting.

For participants enrolled in an MCO, the Plans have processes for receiving medication error reports. The Plans also have processes for managing medication errors, including case management processes as well as reporting processes. Medication errors are forwarded to Medical Directors for review and follow up. These instances are also forwarded to the routine Peer Review Committee in MCOS for review, investigation and recommendations for follow-up. The procedures include processes for ensuring participant safety.

- (b) Specify the types of medication errors that providers are required to *record*:

Medication errors must be reported for participants who receive medication management services from the Supportive Living Program provider. These services include medication set-up, verbal reminders and administration. The SMA defines a medication error as the wrong medication, wrong dose, wrong time (in excess of one hour in most instances), wrong route or a missed medication. These reports must be made available upon the SMA's request.

- (c) Specify the types of medication errors that providers must *report* to the state:

Medication errors that result in adverse reactions requiring hospitalization must be reported in writing to the SMA within 24 hours on the Medication Error Report form. The form includes the name of the participant involved, the medication(s) and the type of error (i.e, time, dosage, etc.) and any adverse reaction observed. Additionally, the Supportive Living Program (SLP) provider must document that the physician and emergency contact were notified and include information regarding any instructions provided by the physician. Finally, the SLP provider must provide a plan of correction to prevent future errors.

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

- iv. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

SMA staff monitors medication management services received by waiver participants annually during on-site certification reviews and also continuously and ongoing in response to complaints. During on-site reviews, the records of participants are reviewed, including documentation of medication management services and physician's orders, as well as Medication Error Reports. SMA staff verifies participants are receiving the medication services they need based on their comprehensive assessment, that physician orders are followed and that medication management services are documented as required. Medication Error Reports are reviewed for completeness and accuracy. SMA staff also verifies that medication administration is performed only by licensed nurses. Participants and Supportive Living Program (SLP) provider staff are also interviewed. SMA staff can observe the delivery of medication management services, if necessary.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. **Sub-Assurances:**

- a. *Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:

Number/percent of waiver participants whose funds are managed by the SLP provider according to program regulations. Numerator: Number of waiver participants whose funds are managed by the SLP provider according to program regulations. Denominator: Total number of waiver participants reviewed who received management of funds by the SLP provider.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95%</div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of dementia program waiver participants whose funds are managed by the SLP provider according to program regulations. Numerator: Number of dementia program waiver participants whose funds are managed by the SLP provider according to program regulations. Denominator: Total number of dementia program waiver participants reviewed who received management of funds by the SLP provider.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

Number/percent of interviewed waiver participants who report their rights, choices and preferences are respected. Numerator: Number of interviewed waiver participants who report their rights, choices and preferences are respected. Denominator: Total number of waiver participants interviewed.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95%</div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: <input type="text"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of waiver participants' instances of alleged abuse, neglect, exploitation other crimes appropriately reported to the SMA, MCO and local law enforcement. N: # of waiver participants' instances of alleged a/n/e and other crimes approp. reported to the SMA, MCO and local law enforcement. D: Total # of waiver partic. with instances of alleged abuse, neglect, exploitation and other crimes.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

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

	Ongoing	Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number/percent of interviewed dementia program waiver participants who report their rights, choices and preferences are respected. Numerator: Number of interviewed dementia program waiver participants who report their rights, choices and preferences are respected. Denominator: Total number of dementia program waiver participants interviewed.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

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

<i>(check each that applies):</i>		
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

#/% of dementia prog. partic.s' instances of alleged abuse, neglect, exploitation and other crimes approp. reported to the SMA, MCO and local law enforc. N:# of dementia prog. partic.s' instances of alleged a/n/e and other crimes approp. reported to the SMA, MCO, and local law enforc. D: Total # of dementia prog. partic. with alleged abuse, neglect, exploitation and other crimes.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

Performance Measure:

Number/percent of participant records reviewed where the participant received information about how and to whom to report A/N/E at the time of assessment. Num: Number of participant records reviewed where the participant received information about how and to whom to report A/N/E at the time of assessment. Denom: Total number of participant records reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100%

		Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <input type="text" value="95%"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <input type="text" value="EQRO"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

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

Performance Measure:

#/% of dementia program participant records reviewed where the participant received information about how and to whom to report A/N/E at the time of assessment. Num: Number of dementia program participant records reviewed where the participant received information about how and to whom to report A/N/E at the time of assessment. **Denom:** Total number of dementia program participant records reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

Number/percent of participant deaths as a result of substantiated case of A/N/E where appropriate follow up actions were implemented by the SMA. Numerator: Number of participant deaths as a result of a substantiated case of A/N/E where appropriate follow-up actions were implemented by the SMA. Denominator: Total number of participant deaths as a result of a substantiated case of A/N/E.

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative

		Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

#/% of dementia prog. participant (partic.) deaths as a result of substantiated case of A/N/E where appropriate follow up actions were implemented by the SMA. Num: # of dementia prog. partic. deaths as a result of a substantiated case of A/N/E where appropriate follow-up actions were implemented by the SMA. Den: Total # of dementia prog. partic. deaths as a result of a substantiated case of A/N/E

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

b. *Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

Number/percent of incident reports requiring additional review by the SMA completed within the required timeframes as described in the approved waiver.
Numerator: Number of incident reports requiring additional review that were completed by the SMA within the required timeframes. **Denominator:** Total number of incident reports that required additional review.

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

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

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number/percent of substantiated cases of A/N/E where the SLP provider implemented a plan of correction and was determined to be in compliance by the SMA. Numerator: Number of substantiated cases of A/N/E where the SLP provider implemented a plan of correction and was determined to be in compliance by the SMA. Denominator: Total number of substantiated cases of A/N/E.

Data Source (Select one):

Other

If 'Other' is selected, specify:

SMA on-site monitoring review of SLP provider.

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

	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	
--	---	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

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

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

Performance Measure:

Number/percent of waiver participants who are free from seclusion or restraints.

Numerator: Number of waiver participants who are free from seclusion or restraints.

Denominator: Total number of waiver participants reviewed.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95%</div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

Number/percent of dementia program waiver participants who had an elopement risk assessment completed according to program requirements. Numerator: Number of dementia program waiver participants who had an elopement risk assessment completed according to program requirements. Denominator: Total number of dementia program waiver participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and	<input type="checkbox"/> Other

	Ongoing	Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin: 5px auto;"></div>

Performance Measure:

Number/percent of dementia program waiver participants who are free from seclusion or restraints. Numerator: Number of dementia program waiver participants who are free from seclusion or restraints. Denominator: Total number of dementia program waiver participants reviewed.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

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

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

#/% of dementia partic. referred to another setting when the elopement risk assess. no longer showed a need for an alarmed delayed exit door intervention. Num: # of dementia partic. referred to another setting when the elopement risk assess. no longer showed a need for an alarmed delayed exit door intervention. Denominator: Total # of dementia partic. requiring referral to another setting.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other	

	Specify:	
	<input style="width: 100%; height: 20px;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

d. Sub-assurance: *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

Number/percent of medication errors documented and reported to the SMA.

Numerator: Number of medication error reports documented and reported to the SMA. **Denominator:** Total number of incidents of medication errors requiring documentation and reporting to the SMA.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medication Error Reports

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number/percent of waiver participants who receive well-being checks in accordance with program rules. Numerator: Number of waiver participants receiving well-being checks in accordance with program rules. Denominator: Total number of waiver participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block; margin-top: 5px;">95%</div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

Number/percent of waiver participants who have working emergency call systems in their apartments. Numerator: Number of waiver participants with working emergency call systems in their apartment. Denominator: Total number of waiver participants reviewed.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

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

<i>(check each that applies):</i>		
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: 50px; margin-left: 20px;">95%</div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number/percent of medication errors for dementia program waiver participants documented and reported to the SMA. Numerator: Number of medication error reports for dementia program waiver participants documented and reported to the SMA. Denominator: Total number of incidents of medication errors requiring documentation and reporting to the SMA.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medication Error Report

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

Number/percent of dementia program waiver participants who received well-being checks in accordance with program rules. Numerator: Number of dementia program waiver participants receiving well-being checks in accordance with program rules. Denominator: Total number of dementia program waiver participants reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

Agency		
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Performance Measure:

Number/percent of dementia program waiver participants with working emergency call systems in their apartments. Numerator: Number of dementia program waiver participants with working emergency call systems in their apartment. Denominator: Total number of dementia program waiver participants reviewed.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

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

b. Methods for Remediation/Fixing Individual Problems

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

Incident Reporting:

If a Supportive Living Program (SLP) provider did not report alleged abuse, neglect, exploitation or another crime against a waiver participant to the SMA and local law enforcement, it would be required to be submitted at the time this was discovered by the SMA. SMA staff reviews the required Preliminary Incident Report for completeness and accuracy to confirm remediation. In a case of alleged participant abuse, neglect or exploitation, the SMA would confirm local law enforcement had been notified. If a participant's safety was a concern at the time the allegation of abuse, neglect or exploitation was discovered, the SMA would review what steps the SLP provider had taken to keep the resident safe, such as placing an accused employee on administrative leave pending an investigation, and determine if further steps needed to be taken. SMA staff could also assist the participant with identifying temporary or permanent relocation options as well.

The SMA also tracks incidents by type, SLP provider and participant to monitor for patterns.

SMA Review of Incident Reports:

If SMA staff was found to be late with conducting on-site reviews related to incident reports or submitting summaries as required, the investigation/report would have to be completed immediately. Staff would also receive a reminder clarification regarding agency procedures for follow-up of incident reports. Continued non-compliance could result in administrative personnel action.

Participant Rights/Choices:

If a participant alleged his/her rights or choices were not being respected, SMA staff could investigate further. This could include reviewing the participant's record, interview of other participants, SLP provider staff interviews, and the review of provider policies. If the SMA discovered resident rights were not respected, findings of non-compliance could be issued (see below).

Medication Error Reports:

If it was discovered a Medication Error Report requiring submission to the SMA had not been sent, the SLP provider would need to complete a report (if not done previously) and send it immediately. SMA staff would review the report form for completeness and accuracy to verify remediation. Findings of non-compliance could be issued (see below).

Well-being Checks:

If it was discovered a waiver participant did not have required well-being checks completed, the SMA could issue findings of not-compliance (see below). If checks had not been completed at all, SMA staff would remain on-site until the SLP provider remediated the non-compliance.

Emergency Call Systems:

If an emergency call system was not functioning in a waiver participant's apartment, the SLP provider would have to repair the system immediately or supply an alternative way for the participant to signal for help until the system was repaired. The SMA would have to approve the alternative alert. SMA staff would verify the system was repaired to document remediation. Findings of non-compliance could be issued (see below).

Freedom from Restraints and Seclusion:

If a participant was found in restraints or seclusion, or SMA learned a participant had been restraints or seclusion, the SLP provider would have to discontinue this practice immediately. SMA staff would verify the participant was not in restraints or seclusion in order to document remediation. Findings of non-compliance could be issued (see below). The SMA could also issue a notice of immediate jeopardy, as outlined in Appendix G.

Management of Resident Funds:

If a participant's funds were found not be managed by the SLP provider in accordance with regulations, SMA staff would instruct the SLP provider to correct this issue. SMA staff would confirm remediation had occurred. Findings of non-compliance could be issued (see below). If it was suspected the SLP provider was intentionally mismanaging participants' funds, the SMA's Office of Inspector General (OIG) would be notified to investigate further. Depending on the situation, the Illinois State Police could become involved at the request of the OIG.

Elopement Risk Assessment (dementia program ONLY):

If an elopement risk assessment had not been completed for a dementia program waiver participant, one would

need to be done immediately. SMA staff would verify the completion of the assessment. If SLP provider staff did not refer a dementia program waiver participant to another community setting when their elopement risk assessment no longer indicated a need for an alarmed delayed exit door intervention, this referral would be required to be made immediately. SMA staff would perform follow-up to verify the referral information had been provided to the dementia program participant or his/her designated representative. Findings of non-compliance could be issued (see below).

In all cases of non-compliance with program rules outlined above, the SMA could issue findings of non-compliance for individual problems when discovered, including for the dementia program and for participants enrolled with an MCO. The SLP provider is presented with a form outlining the areas of non-compliance. A plan of correction must be submitted to the SMA within fourteen days of receipt of the form and must be implemented within 30 days. SMA staff performs an on-site follow-up review to verify remediation has occurred and to verify compliance. If non-compliance is still identified, the SLP provider receives another form outlining the non-compliance areas and is given another 30 days to correct. Continued non-compliance during a second on-site follow-up review by SMA staff results in sanctions, including but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with relocation, including transferring to another SLP provider.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

No

Yes

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

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The SMA is responsible for the overall development and implementation of the Quality Improvement Strategy (QIS) for the Supportive Living Program (SLP) waiver. SMA staff performs on-site reviews continuously and ongoing to determine if requirements of the program are being met and that remediation occurs when necessary. Required reports are submitted by SLP providers continuously and ongoing. Data related to discovery of non-compliance and remediation is aggregated annually and reviewed by the SMA and Quality Workgroup. This can occur more frequently if it is suspected there is a significant issue of non-compliance with regulations.

A Quality Workgroup assembled by the SMA assists with the QIS development, processes, implementation and monitoring. The Workgroup is a collaboration of SMA staff, SLP providers, trade association staff, state agency staff involved with other HCBS waivers and long term care ombudsman. Members review QIS data and reports compiled by SMA staff in order to respond to patterns and trends that identify a need for system improvements, as well as monitoring ongoing quality improvement. The Quality Workgroup meets at least annually. Assurance Teams comprised of a smaller number of Workgroup members may be assembled to focus on patterns/trends of non-compliance for a specific assurance or performance measure. This would include developing a proposed QIS for review and approval by the Workgroup. Assurance team members can meet more frequently, as assignments require. Team members draft proposed system improvement recommendations, including performance measures, acceptable remediation, data sources and how improvement will be measured. These proposals are then presented to the Quality Workgroup to establish priority and final approval. SMA staff is responsible for follow-up at subsequent meetings to make sure action items identified and assigned at a previous meeting are addressed.

The QIS process begins with SMA staff compiling discovery and remediation information from annual certification reviews, critical incident reports, medication error reports and other sources identified in the approved waiver. This data is assembled into an individual report. Information in the report includes the numerator and denominator of the performance measure, data sources and any identified patterns or trends for a particular geographic area or provider group. This information is shared with Quality Workgroup members.

Performance measures with less than 86% compliance are identified as areas that require system improvement. Identified system improvement areas are then prioritized by Workgroup members based on severity, impact on waiver participant health and safety, frequency and geographic distribution of occurrences. Once prioritization is established, performance measures requiring system improvement are delegated to the appropriate Assurance Team. Members then begin developing interventions for possible system design changes. Data sources and options for measuring each system design change are also identified so that continuous quality improvement can be tracked.

Examples of interventions for system design changes could include:

- Program administrative rule changes
- Program policy and procedure changes
- Written clarification for SLP providers and/or SMA staff
- Resource tools for SLP providers and/or SMA staff
- Formal training
- Standardized forms

For managed care services, the SMA and External Quality Review Organization (EQRO) meet with MCOs on a quarterly basis to review data collected from on-site reviews. Reports compiled by the EQRO are provided to the SMA for review prior to the quarterly meeting. Annual reports are produced that identify trends based on the representative sample and/or 100% review of the data. Data will be reported by individual performance measures. Data to be reported will include level of compliance and timeliness of remediation based on immediate, 30, 60 and 90 day increments and any outstanding remediation.

During quarterly meetings, the SMA, EQRO and MCOs will discuss trends based on scope, severity, changes and patterns of compliance by reviewing both the level of compliance with the performance measures and remediation activities conducted by the MCOs. Identified trends will be discussed and analyzed regarding cause, contributing factors and opportunities for system improvements. Systems improvement will be prioritized based on factors such as: the impact on the health and welfare of waiver participants, legislative considerations and fiscal considerations. The MCOs will maintain a separate quality management system and improvident logs. Recommendations for system improvement will be added to the logs for tracking purposes. The MCOs will document the systems improvement implementation activities on its respective log. The SMA will assure the

recommendations are followed through to completion. Decisions and time lines for system improvement will be made based on consensus of priority and specific steps needed to accomplish change. These decisions will be documented on the systems improvement log and will be communicated through the sharing of the quarterly meeting summary and the systems improvement log.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">More frequently as required for monitoring of system changes.</div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The performance system design changes are monitored by the SMA through the collection and analysis of new performance measure data, as well as the comparison of previous data and patterns and trends. Once the need for a system change is identified by the Quality Workgroup, the Workgroup or the Assurance Team may develop a proposed system change(s), recommend data source(s), samples size(s) and measure(s) for tracking outcome(s). The proposed processes above may be outlined by the Workgroup, or an Assurance Team and presented to the Quality Workgroup. The Quality Workgroup discusses and determines the final changes(s) to be implemented, which data source(s) will be used and how improvement will be measured.

Once the data source is identified, it is assigned to a database tracking system to capture information from on-site annual reviews, or other designated sources. SMA staff is responsible for the collection of this data and entering it into the database. Any required changes to Medicaid agency policy and procedures, review tools or standardized forms are made and distributed to the appropriate parties. SMA staff will develop reports specific to the system changes and related performance measures so that outcomes may be analyzed by the Quality Workgroup as a whole. Outcomes for system changes will be tracked for a minimum of one year. The Assurance Team will provide the Quality Workgroup with a summary of the performance of the system changes based on the outcomes. The Team will make recommendations as necessary for any revision to the system changes and explain why they are necessary. The Quality Workgroup will discuss and any approved revision to the system changes will be implemented, as outlined in the process above. This process will be repeated until such time as the system change has proved to be an effective quality improvement strategy (QIS). A system change will continue to be monitored for at least one additional year after it is deemed an effective QIS strategy to ensure continued quality improvement is demonstrated. The Quality Workgroup may also choose to designate the system change as a permanent part of the continuous quality improvement process.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Workgroup meets annually to review and evaluate the quality improvement strategy (QIS), including any in-process system changes. Reports containing data individualized for specific performance measures are developed by the SMA and distributed to Workgroup members. Patterns and trends, areas requiring system changes and any areas currently undergoing improvement are discussed. Additionally, at the request of an Assurance Team, the SMA can compile data reports for performance measures at any time, if the members are interested in reviewing system change outcomes more frequently.

The overall QIS is evaluated by the Quality Workgroup members at least annually. This includes evaluating current monitoring practices to ensure the information being gathered is the best data source for the performance measure, if the sample size is appropriate and also if SMA staff is interpreting the review process appropriately. Additionally, the Workgroup will review the priority ranking of system changes to verify that all areas impacting participant health and safety are being addressed.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

- No
 Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

- HCBS CAHPS Survey :
 NCI Survey :
 NCI AD Survey :
 Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Supportive Living Program (SLP) providers rates are set by the SMA. A flat rate is paid for all services provided each day a Medicaid participant resides in a SLP provider building. Historically SLP provider fee-for-service payments have been generated by the SMA based upon participant data entered into the SMA's long term care database by staff of the Department of Human Services (DHS) and SLP providers. Information regarding participant admission, third party liability coverage, income changes and patient credit updates, discharge and death are communicated electronically by providers to DHS staff. DHS staff enters participant admissions, income and patient liability changes into the SMA's long term care database. Provider submissions regarding discharge or death go live into the long term care database and do not require review and entry by DHS staff. This process is effective for services provided through November 30, 2016.

Effective for services provided December 1, 2016 and after, SLP providers submit electronic claims each month to the SMA for Medicaid participants via the Department's Internet Electronic Claim system. Providers follow the UB04 and 837I Implementation guidelines to submit claims. Claim information includes the dates a participant is in the SLP building, temporary absence days and third party liability coverage. Claims are verified with information in the long term care database to ensure payment is made for Medicaid eligible participants who have been admitted to a SLP provider building, per review and approval by DHS staff. This review also ensures the correct daily reimbursement rate is paid.

SLP providers are also paid by Managed Care Organizations (MCO) with which the SMA contracts. The MCOs, through the Integrated Care Program (ICP), Medicare Medicaid Alignment Initiative (MMAI), Long Term Service and Supports (LTSS) and the Family Health Program (FHP) receive monthly capitated payments from the SMA and are responsible for managing and paying for the care of specific participants. The SLP providers bill the MCOs on a monthly basis and receive their payments directly from the MCO. The MCOs are required to have an internal process to validate payments to SLP providers, including a claims processing system verifying an individual's eligibility for SLP services. In addition, MCOs are required to submit their paid claims to the SMA as encounter data that is processed through the SMA's MMIS to verify that payments were paid appropriately to Medicaid eligible providers for eligible participants.

A SLP provider representative must sign a remittance advice that accompanies each payment voucher to verify that the provider accepts the payment amount is correct. The remittance advice and the signature certification documents must be kept on file by the SLP provider for three years. In addition, SLP providers are required to submit cost report information on an annual basis to the SMA. The SMA's Bureau of Health Finance audits the cost reports and maintains the historical cost information.

The SMA's Office of Inspector General (OIG) has statutory authority to oversee the integrity of the Illinois Medicaid program in order to prevent, detect and eliminate fraud, waste and abuse. Pursuant to this authority, the OIG performs pre-payment and post-payment audits of SLP providers to ensure that appropriate payments are made for services rendered and to prevent and recover overpayments. The scope of the review for SLP providers includes but is not exclusive to: room and board ledgers, required SMA transactions related to payment generation, disbursement of participant personal allowance, temporary absences and participant cost of care received by the SLP provider. Additional areas of review include missing or insufficient medical records and signatures, as well as reviews of medical necessity of services billed.

All services for which charges are made to the SMA are subject to audit. During a review audit, the provider must furnish to the SMA's OIG or to its authorized representative, pertinent information regarding claims for payment. Should an audit reveal that incorrect payments were made, or that provider's records do not support the payments that were made, or should the provider fail to furnish records to support payments that were made, the provider is required to make restitution.

The SMA's OIG conducts both desk audits and field audits of SLP providers. Desk audits employ algorithms that analyze specific program billing reimbursement data that can be automatically validated. Claim data elements and established law and policy are used to determine if an overpayment was made. The overpayment amounts are verified through analytical methods. Field audits employ algorithms that analyze data that cannot be automatically validated, thus requiring a manual review of medical and other documentation.

The SMA's procedure for auditing providers can involve the use of sampling and extrapolation. Under such a procedure, the SMA selects a statistically valid sample of services for which the provider received payment for the audit period in question and audits the provider's records for those services. All incorrect payments determined by an audit of the services in the sample are then totaled and extrapolated to the entire universe of services for which the provider has been paid during the audit period. The provider is required to pay the SMA the entire extrapolated amount of incorrect payments calculated under this procedure after Final notice and/or an opportunity for hearing.

The SMA's OIG has the legal authority to perform audits on Medicaid providers during the course while the Medicaid provider is an active provider during the audit review period. The OIG has the legal authority to perform an audit on dates

of service six years prior to when the audit is being commenced. A Medicaid audit can commence at any time although once a provider is audited, it is generally 1-2 years before a provider can be subject to an additional audit for the same audit reasons. The determination of the frequency of OIG audits depends upon many different factors, such as internal and external referrals and prioritization of audits.

The audit period depends upon the type of audit being performed. Audits are based upon dates of service and the OIG has the legal authority via Public Act 97-0689 to go back six years prior to when the audit is being commenced. For a sample/extrapolation audit, the audit period typically has 3 years of services reviewed. During a 100% audit, the audit period is typically 2 years of services. The type of audit (sample/extrapolated vs. 100%) is dependent upon the number of services billed and paid for by the SMA during the course of a three year time frame and is also dependent upon a referral reason for the audit.

MCOs also conduct post-payment plans of care and financial reviews. Additionally, the MCOs complete call-in checks for some waiver services to verify a provider was supplying services during the specified time(s) and post service verification forms for participants to validate they received services.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

Number/percent of payments made by the SMA for individuals enrolled in the Medicaid waiver. Numerator: Number of payments made by the SMA to waiver providers and MCOs for individuals enrolled in the Medicaid waiver. Denominator: Total number of waiver provider and MCO payment records reviewed.

Data Source (Select one).

Other

If 'Other' is selected, specify:

MMIS

Responsible Party for	Frequency of data	Sampling Approach(check
------------------------------	--------------------------	--------------------------------

<i>data collection/generation (check each that applies):</i>	<i>collection/generation (check each that applies):</i>	<i>each that applies:</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample Confidence Interval =</i> 95%
<input type="checkbox"/> <i>Other Specify:</i> 	<input checked="" type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified Describe Group:</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Other Specify:</i>
	<input type="checkbox"/> <i>Other Specify:</i> 	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

Number/percent of payments made for waiver services using the correct reimbursement rate. Numerator: Number of SMA and MCO payments using the correct rate.
Denominator: Total number of SMA and MCO payments reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; width: 50px; text-align: center; margin: 0 auto;">95%</div>
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified

<i>Specify:</i> <input type="text"/>		<i>Describe Group:</i> <input type="text"/>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Other Specify:</i> <input type="text"/>
	<input type="checkbox"/> <i>Other Specify:</i> <input type="text"/>	

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

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>100% Review</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Less than 100% Review</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>	<input checked="" type="checkbox"/> <i>Representative Sample</i> <i>Confidence Interval =</i> <input type="text" value="+/-5"/>
<input type="checkbox"/> <i>Other Specify:</i> <input type="text"/>	<input checked="" type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified Describe Group:</i> <input type="text"/>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>	<input type="checkbox"/> <i>Other Specify:</i> <input type="text"/>

	<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
--	--	--

Data Aggregation and Analysis:

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis(check each that applies):</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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

The SMA monitors compliance of performance measures and timeliness of remediation for those waiver participants (partic.) enrolled in a MCO. Partic. in MCOs are included in the representative(rep.) sampling. This review will include encounter claims submitted by MCOs. A random sample of MCO enrollees is reviewed.

Monitoring of the use of the correct reimbursement rate requires review of claims data and encounter data pulled from MMIS. Claims are priced by procedure code. The SMA will determine if the correct rate was used. The State's Auditor General currently contracts with KPMG to conduct the audit applicable to the Single Audit Act.

Personal care services (svcs.) are part of the waiver svc. package. Payment to SLP providers (prov.) is a flat daily rate regardless of the type or amount of svcs. requested and received by the partic. The type and frequency of svcs. is included in the partic.'s service plan.

During annual on-site certification reviews at each SLP prov., the SMA completes a record review for each new waiver partic. and a random, rep. sample of continuous waiver partic. This includes a thorough review of the partic.'s assess., plan of care, MD orders, nursing notes and medication assist. documen. A random, rep. sample of partic. are also interviewed. This verifies staff of the SLP prov. is supplying svcs. to eligible partic. with the frequency, amount and duration specified in the plan of care. Additionally, MMIS does not allow payment reimbursement for people who have not been determined to be eligible for the waiver. The SMA's OIG also completes post payment reviews.

The SMA also completes on-site, unannounced complaint investigations. Complaints are received through the SMA's complaint hotline, email, written correspondence and in-person with SMA staff. The SMA's hotline number is on posters required to be displayed in each floor of the SLP prov. building. Placement of posters is verified at the time of the initial certification review and annually thereafter. The hotline number is also included on the SMA's Resident Rights brochure that is distributed to waiver partic. during initial and annual assessments. SMA staff verifies the receipt of brochures during record reviews and interviews with a rep., random sample of continuous waiver partic. at each SLP provider annually.

Edits in the SMA's MMIS prevent prov. from billing the SMA for duplicative svcs. The SMA has duplicate claim checks for fee for svc. and encounter claims w/ MMIS. MMIS compares hospital claim data and will void a SLP claim if it overlaps with a hospital or nursing facility (NF) claim.

When a waiver partic. is admitted to a NF, the SLP prov. is required to discharge the partic. in the SMA's data interchange system. The NF enters an admission into the SMA's data interchange system. MMIS does not allow a client to have an admission to an SLP prov. and NF at the same time.

MMIS only allows payment to certified prov. The SMA certifies SLP prov. initially and annually. The SMA also processes Medicaid prov. enrollment. Until a SLP prov. is certified and enrolled as a Medicaid prov. by the SMA, MMIS will not allow payments to be issued. When an SLP prov. is terminated from the Medicaid program, MMIS prevents payment from being issued.

SLP prov. are certified by the SMA through an on-site review process prior to providing svcs. and annually. This includes a review of SLP prov. staff. The SMA verifies SLP prov. staffing and the qualifications of Certified Nurse Aides and licensed nurses, who provide personal care to waiver partic. The SMA verifies SLP prov. staff certifications, licensure and required criminal background checks.

The SMA's MMIS only allows payment to be issued to certified SLP prov. that are enrolled Medicaid prov. Payments are issued to the SLP prov., not individual SLP prov. staff who supply direct care and other svcs. SLP prov. receive a flat daily rate.

If the SMA discovers an SLP prov. is not supplying svcs. as outlined in the partic.'s plan of care, findings of non-compliance are cited. The SLP prov. has 30 days to develop and implement a plan of correction. The SMA performs an unannounced on-site follow up review. If non-compliance is still identified, the SLP prov. is given another 30 days to remediate. If the second unannounced on-site follow up review still identifies non-compliance, sanctions are issued up to and including provider termination. In this instance, SMA staff would assist partic. with transferring to a new prov.

Additionally, the SMA's Office of Inspector General (OIG) is notified if Medicaid fraud is suspected. The OIG can also involve the IL State Police in reviews of Medicaid fraud.

SLP prov. receive a daily per diem and the SMA's MMIS contains duplicate claim logic that will reject multiple claims for the same date of service. There are edits in the SMA's MMIS to prevent prov. from billing the SMA for managed care clients. When a partic. is enrolled in managed care, MMIS will not allow the SMA to issue a payment for any svcs. covered by managed care, including waiver svcs. If a prov. bills the SMA for a partic. for svcs. covered by managed care, the claim will reject with the "Recipient in MCO" message.

Additionally, the MCOs receive a monthly file from the SMA with information for SLP waiver partic. The report is generated from MMIS and includes MCO enrollment and SLP waiver eligibility. The SMA's contract with the MCOs states payment should not be issued prior to confirmation the partic. is included in the report.

Suspected abuse is reported to the SMA and local law enforcement. Substantiated abuse by an SLP provider results in findings of non-compliance being issued (see process above). A notice of immediate jeopardy is issued if it is determined by the SMA there is an immediate threat to partic. health and safety.

The SMA is accountable for the proper administration of the systems and procedures described above.

b. Methods for Remediation/Fixing Individual Problems

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

Payment for Non-waiver participant:

If the SMA discovers that payment has been issued for waiver services for an individual not enrolled in the waiver at all, or not enrolled for a certain period, a non-allowable service period is identified. The SMA would then recover any reimbursement made during the non-allowable service period. SMA staff manually change the admission date to the waiver or delete an admission date, as appropriate, in the long term care data base. This would result in MMIS making an automatic adjustment to reduce a future payment to the SLP provider.

If the individual problem is found to be the result of an error made by a Department of Human Services (DHS) caseworker, the SMA would communicate this to supervisory staff at DHS. The employee could receive clarification/training regarding correct entry in to the long term care database. Continued problems could result in administrative personnel action.

Additionally, the SMA's Office of Inspector General (OIG) is notified if Medicaid fraud is suspected. If the OIG's investigation resulted in termination of a Medicaid provider agreement, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

Incorrect Reimbursement Rate:

If the SMA discovered an incorrect reimbursement rate was used to generate a payment for a waiver participant, the provider reimbursement database would be corrected to reflect the correct reimbursement rate. Correction to the reimbursement rate for waiver services would be generated automatically by MMIS based on the revised rate. This would result in an adjustment, either up or down, to future payment.

Additionally, the SMA's OIG would be notified if Medicaid fraud was suspected. If the OIG's investigation resulted in termination of a Medicaid provider agreement, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

For those functions delegated to a contracted entity, the Plans are responsible for addressing individual problems as they are discovered. The SMA monitors both compliance and timely remediation through monitoring and reporting by the plans.

ii. Remediation Data Aggregation

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

<i>Responsible Party(check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input checked="" type="checkbox"/> <i>Annually</i>
	<input type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

- No*
- Yes*

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

Waiver Years 1-2

Supportive Living Program (SLP) rates for conventional SLP providers were originally calculated based upon 60% of the weighted average reimbursement rate for nursing facilities in the same geographic area, excluding room, board and other Medicaid prohibited costs provided to participants. SLP rates are a flat daily rate and are not tied to the type of service or the frequency of services provided.

The rate for SLP waiver dementia care settings was originally based upon 72% of the nursing facility rate, excluding room, board and other Medicaid prohibited costs. This percentage was developed using comparisons of resident care costs in nursing facilities providing dementia care with the rate paid by the SMA, which includes a specific add-on to the daily reimbursement rate (excluding room, board and related costs) for each participant receiving these services. Input was sought from the trade association representing SLP providers regarding actual program cost information and inclusion of other relevant costs, e.g. liability insurance. The SMA also consulted with representatives of the Illinois Alzheimer's Association to learn about other states' programs, as well as components of the reimbursement system used by the "private pay" assisted living market in Illinois. In all deliberations and calculations, SMA staff was careful to separate the cost of room and board charges paid by participants from any overall rate calculations.

The dementia care setting rate reflects the cost of increased staffing and services necessary to meet the scheduled and unscheduled clinical and supportive service needs of participants. For instance, a minimum of one certified nurse aide is required for every ten participants in a dementia care setting. Licensed nursing services are increased due to participants' needs for medication administration. Additional required services for dementia care settings that differ from a conventional SLP provider include well being checks at least once every shift and scheduled activities a minimum of three times daily. The unscheduled needs of participants in dementia care settings require more staff interaction as well. For example, increased verbal cuing, redirection and assistance with activities of daily living are provided by staff.

The SMA sought to strike a balance between giving providers a reimbursement rate that would allow them to provide safe, quality care to participants in need of dementia services, while still ensuring cost neutrality for the waiver. SMA staff analyzed nursing facility reimbursement rates for dementia services at various levels to ascertain what level of rate would result in cost effectiveness, while still offering providers a competitive rate. The rate of 72% was the highest percentage that could be justified and still result in cost neutrality.

Public Act 97-0689 separated the SLP rates from the nursing facility rate during the previous waiver cycle. Multiple small rate increases were implemented since that time through state legislation.

Waiver Years 3-5

The reimbursement rate methodology for SLP providers is established by Public Act 101-0010. This Public Act sets daily rates for conventional SLP providers at 54.3% of the average total nursing facility services per diem for the geographic areas defined by the SMA while maintaining the rate differential for dementia care and must be updated whenever the total nursing facility service per diems are updated, which is quarterly. This Public Act results in an increased rate for all SLP providers. The methodology was a collaboration of members of the General Assembly, program providers, trade associations and the SMA. It was determined this methodology results in fair and acceptable rates for providers, allowing them to provide required services and quality care, while at the same time ensuring cost neutrality in comparison with institutional care. There are no changes to participant costs or services. In reviewing the fixed unit rate of reimbursement, the SMA takes into consideration (1) service utilization and cost information, and (2) current market conditions and trend analysis with the goal of ensuring client access to high quality services.

SLP rates are not tied to the type of service or the frequency of services provided. However, the SLP provider must supply waiver services to meet participants' needs. Room and board rates, including meals, are paid directly by the participant to the SLP provider and are based on Supplemental Security Income amounts. These payments are separate from the SMA reimbursement rate for SLP services.

The reimbursement system for nursing facilities is a prospective system; that is, the rates are set for each facility for a subsequent rate period. The rates remain in effect for the rate period and there is no retroactive reconciliation of rates to actual expenditures during the rate period. The reimbursement rates are facility specific. Individual rates are set for each nursing facility, taking into account such factors as, individual facility costs, variations in patient case mix, geographic location, and other facility characteristics, such as occupancy level. This occurs quarterly.

The new rate methodology allowed for public comment during the General Assembly legislative process. The Supportive

Living Program waiver amendment also required a 30 day public comment period. There has not been a cap placed on the number of waiver participants and participants are not paying any additional money for these services.

Rate information is available on the SMA's website. The SMA also has email inboxes for the Department as a whole, the Bureau of Long Term Care, which administers the waiver, and also for the Supportive Living Program. Toll free numbers for the Department and the Supportive Living Program are available on the SMA's website, Resident Rights brochures and complaint hotline posters. The website, various emails and phone numbers allow waiver participants access to the SMA to request information about rates.

MCOs are required to pay SLP providers at least the same daily rate as that of fee for service participants.

The methodology of using a percentage of the average nursing facility rate in a geographic area was previously used for the Supportive Living Program from 1999-2012. In 2019, collaboration among members of the General Assembly, program providers, trade associations and the SMA resulted in legislation being introduced and passed that relinks the daily Medicaid rate for the Supportive Living Program at 54.3% of the average nursing facility rate in a geographic area. It was determined this methodology results in fair and acceptable rates for providers, allowing them to provide required services and quality care, while at the same time ensuring cost neutrality in comparison with institutional care. This same methodology was used in the past for the daily Medicaid rate until 2012 when the General Assembly passed legislation that delinked the rates from nursing facilities. Rate changes after 2012 were implemented through legislation passed by the Illinois General Assembly.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Supportive Living Program (SLP) rates are set by the SMA. A flat rate is paid for all services provided each day a Medicaid participant resides in a SLP provider building. Historically SLP provider fee-for-service payments have been generated by the SMA based upon participant data entered into the SMA's long term care database by staff of the Department of Human Services (DHS) and SLP providers. Information regarding participant admission, third party liability coverage, income changes and patient credit updates, discharge and death are communicated electronically by providers to DHS staff. DHS staff enters participant admissions, income and patient liability into the SMA's long term care database. Provider submissions regarding discharge or death go live into the long term care database and do not require review and entry by DHS staff. This process is effective for services provided through November 30, 2016.

Effective December 1, 2016 and after, SLP providers submit electronic claims each month to the SMA for Medicaid participants via the Department's Internet Electronic Claim system. Providers follow the UB04 and 837I Implementation guidelines to submit claims. Claim information includes the dates a participant is in the SLP building, temporary absence days and third party liability coverage. Claims are verified with information in the long term care database to ensure payment is made for Medicaid eligible participants who have been admitted to a SLP provider building, per review and approval by DHS staff. This review also ensures the correct daily reimbursement rate is paid.

SLP providers are also paid by Managed Care Organizations (MCO) with which the SMA contracts. The MCOs, through the Integrated Care Program (ICP), Medicare Medicaid Alignment Initiative (MMAI) and Family Health Program (FHP), receive monthly capitated payments from the SMA and are responsible for managing and paying for the care of specific participants. The capitated payments are generated by the SMA's MMIS based upon a SLP participant's eligibility in the SMA's system for managed care and SLP services. The SLP providers bill the MCOs on a monthly basis and receive their payments directly from the MCO. The MCOs are required to have an internal process to validate payments to SLP providers, including a claims processing system verifying an individual's eligibility for SLP service. In addition, the MCOs are required to submit their paid claims to the SMA as encounter data that is processed through the SMA's MMIS to verify that payments were paid appropriately to Medicaid eligible providers for eligible participants.

A SLP provider representative must sign a remittance advice that accompanies each payment voucher to verify the provider accepts the payment amount is correct. The remittance advice and the signature certification documents must be kept on file by the SLP provider for three years. The SMA's Office of Inspector General audits these documents and reviews participant claims to verify they are paid in accordance with the waiver reimbursement methodology.

Appendix I: Financial Accountability**I-2: Rates, Billing and Claims (2 of 3)****c. Certifying Public Expenditures (select one):**

- No. state or local government agencies do not certify expenditures for waiver services.**
- Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability**I-2: Rates, Billing and Claims (3 of 3)**

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Supportive Living Program (SLP) rates are set by the SMA. A flat rate is paid for all services provided each day a Medicaid participant (partic.) resides in a SLP provider building. Historically SLP provider fee-for-service payments have been generated by the SMA based upon partic. data entered into the SMA's long term care database by staff of the Department of Human Services (DHS) and SLP providers. Information regarding partic. admission, third party liability coverage, income changes and patient credit updates, discharge and death are communicated electronically by providers to DHS staff. DHS staff enters partic. admissions, income and patient liability into the SMA's long term care database. Provider submissions regarding discharge or death go live into the long term care database and do not require review and entry by DHS staff. This process is effective for services provided through November 30, 2016.

Effective December 1, 2016 and after, SLP providers submit electronic claims each month to the SMA for Medicaid partic. via the Department's Internet Electronic Claim system. Providers follow the UB04 and 837I Implementation guidelines to submit claims. Claim information includes the dates a partic. is in the SLP building, temporary absence days and third party liability coverage. Claims are verified with information in the long term care database to ensure payment is made for Medicaid eligible partic. who have been admitted to a SLP provider building, per review and approval by DHS staff. This review also ensures the correct daily reimbursement rate is paid.

The SLP provider is responsible for entering partic. discharges and deaths into the SMA's data interchange system within five days. Additionally, the SMA's long term care database cross references with a database from the Social Security Administration (SSA). If a death is not reported timely by the SLP provider, information from the SSA system interfaces with the long term care database and payments are automatically adjusted accordingly.

If a partic. transfers to a nursing facility and the SLP provider does not notify DHS, DHS would become aware of the discharge when the nursing facility submits admission information. Upon entry of the nursing facility admission information in to the database, the SMA would recover any payments made to the SLP provider after the partic.'s discharge. 89 IL Admin. Code 140.513 requires providers to notify the SMA within five business days of a change of resident status.

Hospital stays and vacations are reported to the SMA as temporary absences. In the event a SLP provider does not notify the SMA of a hospital stay, the system automatically cancels any payment to the SLP provider for the period of the hospitalization. Once the SLP provider submits the temporary absence information via an electronic claim, payment may be generated if the partic. has available temporary absence days. Any delays in notification are recognized by the payment system and payments are not made for claims submitted for these dates. The SMA's Office of Inspector General audits this process.

A SLP provider representative must sign a remittance advice that accompanies each payment voucher to verify the provider accepts the payment amount is correct. The remittance advice and the signature certification documents must be kept on file by the SLP provider for three years. The SMA's Office of Inspector General (OIG) audits these documents.

Claims are verified with information in MMIS to ensure payment is made for Medicaid eligible partic. who have been admitted to a certified, Medicaid enrolled, SLP provider building, per review and approval by the DHS staff. MMIS also includes edits to assure claims are not duplicative of nursing facility, hospital or MCO paid claims. The SMA's OIG audits the billing process. Inappropriate billings are either rejected by MMIS or voided, and are not included in the state's claim for Federal Financial Participation.

Monthly capitated rates are paid by the SMA to the MCOs (Plans). The MCO payment process is automated to generate a monthly capitation to the health plans based on the rate cell of each enrollee each month. The State reviews to ensure the accurate rate is entered into the system, and also spot checks payment reports to ensure payments are made correctly. In addition, per the MCO's contract with the SMA, MCOs are required to review their monthly payment and report any discrepancies to the SMA.

This payment is generated by MMIS based on participant's eligibility for waiver services as identified in the database system. The Plans only receive payment for individuals eligible for waiver services. The State has a monthly capitation program that reads the State's Recipient Database to determine who is enrolled with a particular MCO. The program includes logic that uses the enrollee's eligibility criteria to determine the appropriate rate cell to be used in generating the payment. As a result of this process, a file is created of MCO schedules which are sent on to the State Comptroller for payment. Once the payment has been made by the Comptroller, a file is sent back to HFS by the Comptroller that includes a warrant number and date. The SMA then creates a HIPAA 820 file for each MCO. The 820 file contains the

detailed payment information on each of the MCO's enrollees.

The Plans are required to have internal processes to validate payments to waiver providers. The Plans' claims processing system must verify an individual's waiver eligibility prior to paying claims.

Post-payment plans of care and financial reviews are also conducted to ensure that plans of care are consistent with needs identified in individuals' assessments. Additionally, the Plans complete call-in checks for some waiver services to verify a provider was on-site as required during the specified time(s) and post-service verification forms for participants validate they received services.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Not applicable

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- No. The state does not make supplemental or enhanced payments for waiver services.**
- Yes. The state makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

- No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.**
- Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.**

Specify the types of state or local government providers that receive payment for waiver services and the services that

the state or local government providers furnish:

Supportive Living Program (SLP) buildings may be owned and/or operated by local housing authorities and local governments. These SLP providers do not differ from other providers in the type or amount of services they provide to waiver participants .

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.*
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.*
- The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.*

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.*
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.*

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

The State processes a mass adjustment to recoup the money from a risk corridor or a medical loss ratio calculation at a match rate in proportion to the original capitation payments that were the basis for the calculation. For example, for ACA capitations used to calculate the risk corridor for coverage months from July 2014 through December 2015, 99% of the capitations were claimed at the 100% match rate, so 99% of the ACA risk corridor recoupments are claimed at the 100% match rate and returned to CMS. The remaining 1% is split among the match rates at which the original capitation payments used to calculate the risk corridor were paid and returned at the corresponding rate. They are reported on the CMS-64 as Line 10B decreasing adjustments corresponding to the reporting period of the original payment. The federal share is calculated based upon the FMAP rate claimed on the original payment to the MCO.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

- No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

- No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The state contracts with a Managed Care Organization(s) (MCO) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.*
- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.*
- not selected*

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or

sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. *There are no local government level sources of funds utilized as the non-federal share.*

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the

individual.

- As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.*
- b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Room and board rates are determined based on the Supplemental Security Income (SSI) payments available for individuals and married couples and are separate from reimbursement by the SMA for waiver services. Room and board costs are paid directly to the Supportive Living Program provider by the waiver participant. These rates increase whenever SSI amounts increase.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

- No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.*
- Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.*

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

- No. The state does not impose a co-payment or similar charge upon participants for waiver services.*
- Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.*

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible*
- Coinsurance*

- Co-Payment*
- Other charge*

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

- No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: *Nursing Facility*

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	14351.20	1490.00	15841.20	25930.60	1998.69	27929.29	12088.09
2	10847.37	1497.00	12344.37	26469.95	1912.15	28382.10	16037.73
3	22409.88	1504.00	23913.88	27020.53	1829.35	28849.88	4936.00
4	23399.10	1512.00	24911.10	27582.55	1750.14	29332.69	4421.59
5	23414.67	1520.00	24934.67	28156.27	1674.36	29830.63	4895.96

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	12132		12132
Year 2	12465		12465
Year 3	11980		11980
Year 4	12262		12262
Year 5	12453		12453

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

ORIGINAL SUBMISSION:

The estimated length of stay of 232 days for the waiver renewal is based upon the average LOS for State Fiscal Years (SFY) 2011 through 2015.

January 1, 2019 Amendment:

The estimated length of stay of 241 days for the waiver amendment is based upon the average LOS for State Fiscal Years 2013 through 2016.

January 1, 2020 Amendment:

The average LOS represents a weighted average of the average LOS experienced from members in the managed care population and members in the fee-for-service (FFS) population. The average LOS for WY4-5 was revised to 246 days for this amendment, based upon utilization from WY1-2.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Waiver Years 1-2:

The estimated number of waiver participants was derived using State Fiscal Year (SFY) 2015 waiver participant totals and applying a formula to project growth based on the number of new SLP provider apartments expected to be certified during SFY 2018-2022. Factor D estimates are based on payment information from SFY 2015.

For waiver participants receiving waiver services through a Managed Care Organization (MCO), a capitated rate specific to waiver services is used. The capitation rate is certified as actuarially sound. The capitation rate is developed based on the historical fee-for-service payments from SFY 2013-2015. The historical waiver experience will be trended forward to the contract rating years. Further, adjustments will be applied for policy and program changes, as well as anticipated managed care impact adjustments. The capitation rate will also include an administrative and risk load appropriate for the MCO.

Since not all waiver recipients are enrolled in an MCO, Factor D will be developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

There is a decrease in the number of average units per user for Assisted Living between waiver year 1 and 2 because these participants will be transitioning to managed care during waiver year two, thus decreasing the number of days, or units, they are in Assisted Living. Beginning in waiver year 2, participants in Assisted Living will mainly be comprised of persons applying for Medicaid on the date they move into an SLP provider building. In most cases, participants who apply for Medicaid at the time of admission have their Medicaid eligibility determined effective the date of admission. Managed care enrollment is prospective, so participants would be enrolled soon after their eligibility is determined with a future effective date, not the date of admission. The average number of days to process a new Medicaid application for eligibility was used to derive the average units per user in Assisted Living for waiver years 2-5.

Waiver Years 3-5:

The waiver year 3 unduplicated participants are estimated based on unique participant counts as of July 1, 2019. The participant count was annualized to represent the entire waiver year 3 participant count based on historic seasonality and completion factors in the SLP enrollment patterns. Unduplicated participant projections for waiver years 4 and 5 are trended from waiver year 3 participants based on the enrollment growth trends illustrated in the approved filing.

The number of users was adjusted to account for revisions to the unduplicated participants. The distribution for projected number of users across the populations for waiver years 3 through 5 was developed based on the enrollment effective July 1, 2019, which is the effective date for statewide mandatory managed care enrollment.

Average units per user for the FFS population in waiver years 3 through 5 was established at 150 to reflect a daily service and an average period of approximately five months of FFS enrollment prior to managed care enrollment. The average units per users for the managed care populations was estimated based on the remaining units to match the average length of stay since the only service in this waiver is provided daily for all recipients.

For waiver years 3, 4, and 5, # Users was estimated by allocating the estimated unduplicated participants based upon the FFS or managed care program (MMAI, MLTSS, or DA) that SLP waiver participants were enrolled in as of July 2019. The July 2019 enrollment distribution was used because statewide expansion of the MLTSS and DA programs occurred that month and it was the most recent enrollment available.

Since assisted living is a service provided each day to SLP waiver enrollees, we were able to estimate the Avg. Units per User for managed care users in waiver years 3, 4, and 5 using the following steps:

- 1. Calculate the total number of assisted living days for the waiver year as the product of the estimated unduplicated participants and the average length of stay on the waiver*
 - 2. Subtract 150 days for each FFS user*
 - 3. Divide the remaining assisted living days by the number of managed care users*
- FFS indicated that the average length of stay for FFS enrollees in the SLP waiver is approximately 150 days.*

The average cost per unit was increased to reflect reimbursement changes effective September 1, 2019 for

Assisted Living services. The average cost per unit was adjusted for all populations to associate managed care reimbursement consistent with the state's FFS fee schedule. The average cost per unit for waiver year 3 represents a blend of the historical fee schedule amounts of \$74.78 for 2 months and the newly effective rate of \$95.22 for 10 months. Waiver years 4 and 5 reflect a complete year at \$95.22.

- ii. **Factor D' Derivation.** *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' estimates are based on ancillary payment information from State Fiscal Year (SFY) 2013-2015, including both fee-for-service and MCO payments. Factor D' is estimated to increase 0.5% annually during SFY 2018-2022. This percentage is based upon the average historical percentage change for SFY 2013-2015, actual ancillary expenditures per capita for waiver participants and carried forward for SFY 2018-2022.

The capitation rate for waiver participants enrolled in Managed Care Organizations (MCO) includes both waiver services, as identified in Factor D, and ancillary medical and pharmacy services. The capitation rate will be developed based on historical costs for ancillary services for waiver participants from SFY 2013-2015. The historical ancillary service expenditures will be trended forward to the contract rating years. Further, adjustment will be applied for policy and program changes, as well as anticipated managed care impact adjustments. The capitation rate also includes an administrative and risk load appropriate for the MCO.

Since not all waiver recipients are enrolled in an MCO, Factor D' will be developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

- iii. **Factor G Derivation.** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G estimates are based upon claims of recipients residing in nursing facilities age 60 years and over for State Fiscal Year (SFY) 2012-2015. The estimated SFY 2018-2022 average per capita has been increased by an estimated 2.08% based upon averages established over previous periods.

For recipients receiving nursing facility services through a Managed Care Organization (MCO), a capitation rate specific to nursing facility services is used. The capitation rate is certified as actuarially sound. The capitation rate was developed based on historical costs for nursing facility services from SFY 2013-2015. The historical nursing facility experience will be trended forward to the contract rate years. The capitation rate also includes an administrative risk load appropriate for the MCO.

Since not all nursing facility residents are enrolled in an MCO, Factor G will be developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

- iv. **Factor G' Derivation.** *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' is based upon claims data for ancillary services for actual nursing facility residents age 60 years and over for State Fiscal Year (SFY) 2012-2015. The estimated SFY 2018-2022 average per capita has been decreased an estimated 4.33% based upon averages established over previous periods.

The capitation rate for nursing facility residents enrolled in Managed Care Organizations (MCO) includes both nursing facility services, as identified in Factor G, and ancillary medical and pharmacy services. The capitation rate is certified as actuarially sound. The capitation rate is developed based on costs for ancillary services for nursing facility residents from SFY 2013-2015. The historical ancillary service expenditure will be trended forward to the contract rating years. The capitation rate also includes an administrative risk load appropriate for the MCO.

Since not all nursing facility residents are enrolled in an MCO, Factor G' will be developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services	
Assisted Living	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/Unit	Component Cost	Total Cost
Assisted Living Total:							174108810.05
Assisted Living	<input type="checkbox"/>	day	6540	248.12	74.18	120372242.06	
Assisted Living MMAI	<input checked="" type="checkbox"/>	day	3072	222.50	39.90	27272448.00	
Assisted Living MLTSS	<input checked="" type="checkbox"/>	day	1993	248.12	45.22	22361432.90	
Assisted Living ICP/Disabled Adults	<input checked="" type="checkbox"/>	day	527	240.50	32.37	4102687.10	
GRAND TOTAL:							174108810.05
Total: Services included in capitation							53736567.99
Total: Services not included in capitation							120372242.06
Total Estimated Unduplicated Participants:							12132
Factor D (Divide total by number of participants):							14351.20
Services included in capitation							4429.32
Services not included in capitation							9921.88
Average Length of Stay on the Waiver:							241

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							135212516.85
Assisted Living	<input type="checkbox"/>	day	1041	150.00	74.51	11634736.50	
Assisted Living MMAI	<input checked="" type="checkbox"/>	day	3148	222.50	40.39	28290367.70	
Assisted Living MLTSS	<input checked="" type="checkbox"/>	day	7733	261.30	45.06	91049718.47	
Assisted Living ICP/Disabled Adults	<input checked="" type="checkbox"/>	day	543	240.50	32.45	4237694.18	
GRAND TOTAL:							135212516.85
<i>Total: Services included in capitation:</i>							<i>123577780.35</i>
<i>Total: Services not included in capitation:</i>							<i>11634736.50</i>
<i>Total Estimated Unduplicated Participants:</i>							<i>12465</i>
<i>Factor D (Divide total by number of participants):</i>							<i>10847.37</i>
<i>Services included in capitation:</i>							<i>9913.98</i>
<i>Services not included in capitation:</i>							<i>933.40</i>
<i>Average Length of Stay on the Waiver:</i>							241

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							268470382.56
Assisted Living	<input type="checkbox"/>	day	2727	150.00	91.83	37563061.50	
Assisted Living MMAI	<input checked="" type="checkbox"/>	day	2478	271.78	91.83	61844827.24	
Assisted Living MLTSS	<input checked="" type="checkbox"/>	day	5893	271.78	91.83	147074885.76	
Assisted Living ICP/Disabled Adults	<input checked="" type="checkbox"/>	day	881	271.78	91.83	21987608.07	
GRAND TOTAL:							268470382.56
<i>Total: Services included in capitation:</i>							<i>230907321.06</i>
<i>Total: Services not included in capitation:</i>							<i>37563061.50</i>
<i>Total Estimated Unduplicated Participants:</i>							<i>11980</i>
<i>Factor D (Divide total by number of participants):</i>							<i>22409.88</i>
<i>Services included in capitation:</i>							<i>19274.40</i>
<i>Services not included in capitation:</i>							<i>3135.50</i>
<i>Average Length of Stay on the Waiver:</i>							241

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/Unit	Component Cost	Total Cost
Assisted Living Total:							286919803.45
Assisted Living	<input type="checkbox"/>	day	2791	150.00	95.22	39863853.00	
Assisted Living MMAI	<input checked="" type="checkbox"/>	day	2537	273.95	95.22	66178961.70	
Assisted Living MLTSS	<input checked="" type="checkbox"/>	day	6032	273.95	95.22	157347850.61	
Assisted Living ICP/Disabled Adults	<input checked="" type="checkbox"/>	day	902	273.95	95.22	23529138.14	
GRAND TOTAL:							286919803.45
Total Services included in capitation							247055910.45
Total Services not included in capitation							39863853.00
Total Estimated Unduplicated Participants							12262
Factor D (Divide total by number of participants)							23399.10
Services included in capitation							20148.16
Services not included in capitation							2151.00
Average Length of Stay on the Waiver:							246

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							291582937.29
Assisted Living	<input type="checkbox"/>	day	2835	150.00	95.22	40492305.00	
Assisted Living MMAI	<input checked="" type="checkbox"/>	day	2577	274.14	95.22	67269005.03	
Assisted Living MLTSS	<input checked="" type="checkbox"/>	day	6126	274.14	95.22	159910719.76	
Assisted Living ICP/Disabled Adults	<input checked="" type="checkbox"/>	day	916	274.14	95.22	23910907.49	
GRAND TOTAL:							291582937.29
<i>Total Services included in capitation</i>							<i>251000632.29</i>
<i>Total Services not included in capitation</i>							<i>40492305.00</i>
<i>Total Estimated Unduplicated Participants:</i>							<i>12453</i>
<i>Factor D (Divide total by number of participants):</i>							<i>23414.67</i>
<i>Services included in capitation</i>							<i>20163.06</i>
<i>Services not included in capitation:</i>							<i>3252.00</i>
<i>Average Length of Stay on the Waiver:</i>							246

