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 waiver's 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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
This 1915 (c) HCBS Waiver for Persons who are Elderly waiver renewal includes:

1. Inclusion of language described in our Statewide Transition Plan for Compliance with HCBS settings as required by the Centers for Medicare and Medicaid Services (CMS) and published final regulations that pertain to Home and Community-Based Services (HCBS) programs, including 1915 (c) , 1915 (i) and 1915(k) as described in 42 CFR 441.301(c) (4) (5) and 441.710(a) (1) (2). Illinois' Transition Plan was submitted on March 16, 2015 and for this waiver affects primarily services provided in non-residential settings and specifically to the Adult Day Care service. All other services in this waiver are delivered to individuals in their home which is presumed to be an integrated community-based setting. This language is reflected in Attachment 2 of the Main Section.

2. Modifications to processes related to Participant Centered Planning (PCP) in accordance with same rules described above and enable waiver participants to direct the planning process, include representative(s) whom the individual has freely chosen and results in a person-centered plan with individually identified goals and preferences; defined outcomes in the most integrated community setting, and the delivery of services in a manner that reflects personal preferences and choices and assurances of health and welfare. Language reflecting PCP is reflected in Appendix D.

In accordance with these substantive changes, this waiver was posted on May 29, 2015 at the website of the Illinois Department of Healthcare and Family Services (HFS), http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx; with public notification on May 29, 2015 in the Illinois Register providing for a minimum of a 30 day feedback period.

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*):
HCBS Waiver for Persons who are Elderly

C. Type of Request: renewal

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.0143
Draft ID: IL.020.06.00

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

Regular Waiver

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

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

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
Individuals aged 60 or above.

○ **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:
As stated, there are no substantive changes, no concurrent amendment to the 1915 (b) is necessary at this time. The 1915 (b) waiver states how Long-term Services and Supports that are defined in this 1915 (c) renewal are implemented. A companion 1915 (b) waiver was approved in 05/28/2014 with an expiration date of 05/31/2019.
Specify the §1915(b) authorities under which this program operates *(check each that applies):*

- [x] **§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)**

[x] **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 Integrated Care Program, 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 First Nation/Native Americans (Indians), except for voluntary enrollment as indicated in D.2.ii of the SPA.

Effective March 1, 2014, waiver services were administered under the Medicare Medicaid Alignment Initiative (MMAI) for dually enrolled Medicare-Medicaid participants. Under the MMAI, Illinois and CMS has contracted with Health Plans to coordinate the delivery of and be accountable for all covered Medicare and Medicaid services for participating Medicare-Medicaid enrollees. For waiver participants who choose to opt-out of the MMAI, the State provides Long Term Support and Services (LTSS) and other Medicaid covered State Plan services, using the same managed care Health Plans chosen for MMAI.

Initial implementation for the MMAI occurred in the greater Chicago and Central Illinois regions where participants are voluntarily enroll in MMAI. Passive enrollment began in 2014. The SPA amendment was submitted September 2013 to include the MMAI population.

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

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

[x] **A program authorized under §1115 of the Act.**

Specify the program:
The MMAI demonstration operates pursuant to Section 1115A of the Social Security Act.

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

[x] **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 Department of Healthcare and Family Services (HFS), the state Medicaid authority, has delegated the day-to-day operations for the waiver to the Illinois Department on Aging (IDoA). Responsibilities of each agency are defined in an interagency agreement. The Department on Aging (IDoA) is the lead agency for community-based services and supports to Illinois residents, 60+ years of age. IDoA is responsible for eligibility, service plan development and implementation, enrolling waiver providers, reporting to HFS, and assuring services and providers meet established standards. HFS enrolls providers in Medicaid, provides oversight, consultation and monitoring, processes federal claims and maintains an appeal process.

The waiver is part of the Community Care Program (CCP), a larger state program operated by IDoA since 1979. The CCP offers services to persons age 60+ who meet functional and financial eligibility. Those that meet Medicaid eligibility are waiver participants. Those that do not meet Medicaid eligibility are funded with state only monies. Persons may transition in and out of Medicaid eligibility. Services offered are the same for both Medicaid and state funded participants. Just over half of the CCP participants are in the waiver.

There are 13 Planning and Service Areas (PSA) in Illinois, each managed and served by an Area Agency on Aging (AAA). IDoA works in partnership with these not-for-profit corporations and one unit of local government, the City of Chicago. AAAs provide planning and coordination of services and programs in their respective geographic areas.

An entity called the Community Care Program Advisory Committee (CCPAC) advises IDoA on an ongoing basis on reimbursement rates for CCP services, and recommendations regarding issues affecting CCP service delivery. Composition requires representatives from AAAs, Care Coordination Units (CCU), providers, advocates, adults over age 60 and state agencies. HFS attends all CCPAC meetings. HFS actively participates to clarify Medicaid or waiver policy. Participant need for CCP services is determined by local community agencies, Care Coordination Units (CCU)/Case Management Units (CMU), which are under contract with IDoA. Care coordinators (CC) are employed by CCUs.

CCs practice a person-centered approach to assessment, care planning and on-going care coordination. Participants are asked to lead the care processing process. Those that choose not to are still engaged at all levels of assessment and care planning. CCs evaluate applicants need for LTSS using a standardized needs assessment instrument, the Determination of Need (DON). This tool is part of a comprehensive care assessment and designed to identify all needs and risks of the individual, including health and well-being, depression, suicide, substance abuse, and support to and from care givers. In addition, all nursing facility applicants are evaluated prior to admission and, if eligible, are offered the option of LTSS. Participants in CCP are informed of their rights and responsibilities and their role in the person centered plan of care. Rights and responsibilities are defined in brochures and validated at various points of the assessment and planning processes with signatures and other affirmations documenting participation and acknowledgement.

IDoA certifies through an application process and contracts providers of CCP services. Providers must meet standards before being certified. CCs are trained to educate participants on available providers and assist in making informed choices. Participants are given choices and may receive one or more CCP services. Services available under the waiver include homemaker, adult day care, emergency home response service and Automated Medication Dispenser. Other services are available through the Older Americans Act (OAA) and the aging network.

HFS and the IDoA maintain separate but complementary processes to monitor participant welfare, service access and quality. IDoA provides HFS with reports of their monitoring activities, including sanctions. IDoA responds to HFS reports from data obtained in site visits and file reviews conducted by federally approved Quality Improvement Organizations. Negative findings are addressed with corrective actions. HFS and IDoA meet quarterly to discuss reports that identify problematic trends and track the effects of remediation efforts to improve performance.

Effective in 2013, the State delivers care coordination and waiver services through a mandatory managed care delivery system for those waiver participants enrolled in the Integrated Care Program (ICP). The ICP was implemented in the Illinois areas of Cook, DuPage, Kane, Kankakee, Lake and Will Counties.

Effective in 2014, the State added dually enrolled Medicare and Medicaid waiver participants to the managed care delivery system. Waiver services are administered under the Medicare Medicaid Alignment Initiative (MMAI) or the Managed Long-term Supports and Services (MLTSS) through a concurrent 1915(b) waiver. Under the MMAI, Illinois and CMS contracts with Health Plans to coordinate the delivery of and be accountable for all covered Medicare and Medicaid services for participating MMAI enrollees. For those participants who wish to opt-out of the MMAI, LTSS, including waiver services, and other Medicaid services are provided using the same managed care Health Plans as chosen by the State for MMAI. Initial implementation of the MMAI occurred in the greater Chicago and Central Illinois regions.

3. Components of the Waiver Request

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

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

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

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

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

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

- ○ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ◉ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

F. **FFP Limitation**. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

H. **Quality Improvement**. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation

and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
Illinois secures public input into the development of this waiver through two separate statements of public notice and input. One form of public notice is electronic through a posting on the HFS website; http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx; with a link to this same website found at the operating agencies' website. For persons that may not have access to the website, a second, non-electronic publication of the waiver renewal was made available. This non-electronic publication is the Illinois Register issued on May 29, 2015. In the two methods of public notification, the dates of the 30 day public input period were identified. The 30 day public input period is from May 29, 2015 through June 28, 2015.

In addition to these two methods of notification, the operating entity of the waiver sent an e-mail blast with the same language found in the Illinois Register and on the website to its stakeholders which includes provider agencies and care coordination entities. These entities were asked to inform the public of the opportunities as described in the public notice to access a copy of the waiver application from the HFS website described above, or to review a copy at DHS-DRS offices across the State. Amongst all of these locations, the public, statewide, has the opportunity to view the waiver renewal application.

The public notification processes stated how to provide input. The public interested in providing input was asked to e-mail their feedback to the HFS web portal e-mail address: HFS.SWTransitionPlan@illinois.gov; or mail their input to the Illinois Department of Healthcare and Family Services, Attn: Waiver Management, 201 South Grand Ave East, 2nd FL, Springfield, IL 62763.

As discussed above, the public notification indicates that all stakeholders have the opportunity to provide the State input either electronically through the website or non-electronically through the U.S. mail. In addition, the full waiver renewal application is available to the public for comment and Illinois has provided multiple levels of contact with our stakeholders.

A summary of the public notice and comments will be incorporated into the renewal prior to submission to federal CMS. This summary will include modifications to the initial waiver renewal and reasons why the State is not adopting specific comments or recommendations.

In addition, Illinois on June 9, 2014 the Medicaid Authority informed via U.S. Mail and e-mail and sought feedback from our representative of the Tribal Authority or First Nation of Illinois' intent to renew this waiver. This date of notice was 60 days prior to Illinois' original intent to submit the waiver renewal. However, a number of extensions were granted by federal CMS. On May 19, 2015, a second letter was sent via U.S. Mail and e-mail informing of the most recent extension to this waiver and its' posting for public comment. In all letters to the Authority, HFS has offered to meet and discuss the waiver. Evidence of all letters is available through the Medicaid Authority.

Specific to Statewide Transition Plan:

Illinois established a LTSS Inter-Agency workgroup in April, 2014 to address the Statewide Transition Plan (STP) in response to the HCBS new regulations. This workgroup continues to meet throughout the implementation of the STP.
In accordance with CMS-2249-F/2296-F, (iii), Illinois provided a 32-day public notice and comment period with two statements of public notice, one non-electronic and one electronic with several methods to inform and engage the public in providing the State with feedback on the draft Statewide Transition Plan. In addition, Illinois informed and sought feedback from our representative of the Tribal Authority or First Nation. The Plan reflects input received and has been modified accordingly.

Illinois' strategies to comply with public notice and input are detailed in Illinois Statewide Transition Plan to Comply with the Department of Health and Human Services Centers for Medicare and Medicaid (CMS) 2249-F and 2296-F Regarding Home and Community-Based Services (HCBS) Settings Rules in Illinois' 1915c Waivers which was submitted to federal CMS on March 16, 2015 and can be found
at: http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Transition/Pages/default.aspx.

In addition, Illinois hosted six public listening forums at which 175 stakeholders signed attendance sheets and a

webinar in which 265 individuals participated.

The input that was received was incorporated into the Transition Plan or there was indication in the Plan of either the inability of the State to respond or how the State intents to respond to comment in the future.

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: Bennett

First Name: Paul

Title: Senior Public Policy Administrator, Bureau of Long Term Care

Agency: Healthcare and Family Services

Address: 401 S. Clinton, 4th Floor

Address 2:

City: Chicago

State: **Illinois**

Zip: 60607

Phone: (312) 793-0078 **Ext:** ☐ **TTY**

Fax: (312) 793-5278

E-mail: Paul.Bennett@Illinois.gov

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

Last Name: Killough

First Name: Mary

Title: Deputy Director

Agency: Illinois Department on Aging

Address: 1 Natural Resources Way, Suite 100

Address 2:

City: Springfield

State: **Illinois**

Zip: 62702-1271

Phone: (217) 785-2870 **Ext:** ☐ **TTY**

Fax: (217) 785-4477

E-mail: Mary.Killough@illinois.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

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:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

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

Specify the transition plan for the waiver:

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

On March 16, 2015, Illinois submitted its Statewide Transition Plan for compliance with HCBS final rules (2249-F and 2296-F) published on January 16, 2014 impacting this 1915c Medicaid waiver. This is a fairly-recent submission in relationship to the submission of this waiver renewal. These rules require States to ensure that individuals receiving Long-Term Services and Supports (LTSS) have full access to the benefits of community living and the opportunity to receive services in the most-integrated setting appropriate and those rights and privileges are comparable to those afforded to Non-Waiver participants in the community. Illinois' Statewide Transition Plan may be found at:
http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx

Illinois has embarked upon the processes identified in the Statewide Transition Plan to assure all non-residential settings and in particular, those settings that provide adult day services, comport with the federal rules. At the time of this submission, Illinois estimated 56 non-residential settings will probably require remedial action to assure compliance. This number crosses all of Illinois waivers. It is estimated that 6 of these settings are adult day service providers.

The State intends to determine which of the sites discussed above may meet the federal requirements, require remedial action or be recommended to federal CMS for "Heightened Scrutiny." These determinations are to be made on a case-by-case basis and only after a site validation visit occurs. This process includes: 1) a participant survey to be distributed to site/setting participants and/or their representatives; 2) a focus group or series of focus groups depending on the size of the site/setting with participants and/or their representatives; 3) meetings with key staff at the site/setting to review of the self-administered

survey, internal policies and procedures and documentation of community integration; and 4) sample file reviews looking at individual participants' Plans of Care.

The State may request additional stakeholder feedback and documentation from the setting provider in order to make an informed decision regarding the status of the site in relationship to the regulations. For those adult day service settings that fall under the Heightened Scrutiny category, the State will forward this recommendation and the accompanying documentation to CMS.

If a site is determined through the heightened scrutiny process to not demonstrate the qualities of an integrated setting, the section of this renewal application addressing transition includes how the state will assure the health, welfare and safety of the participant to realize, to the best of our abilities, a smooth and seamless transition.

Also, key to our Statewide Transition are planned site visits to further address compliance that may be issues in Illinois statutes, rules, Medicaid authority and operating entities policies, contracts, procedures, forms and the setting's internal policies and practices, all to ensure the highest level of compliance with rules relating to settings. The Illinois Transition Plan has timeline for all of these deliverables.

A more detailed description may be found in Section C-5 regarding activities to address all non-residential setting sites and assurances by the State that sites comport with the rules.

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:

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

   Specify the division/unit name:
   Illinois Department on Aging

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

   b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
   Healthcare and Family Services (HFS) maintains an interagency agreement with the Illinois Department on Aging (IDoA) that outlines the HCBS waiver responsibilities of both agencies. As the Operating Agency, IDoA is responsible for participant eligibility, service plan development, Community Care Program budgeting, enrolling waiver providers, assuring service plans are implemented and that services and providers meet standards established in the approved waiver and governing rules. The Medicaid Agency enrolls providers in Medicaid, provides oversight consultation and monitoring of waiver operations, processes federal claims and maintains an appeal process. The interagency agreement is reviewed at least annually and updated as needed. The Medicaid agency's Medical Policy Review Committee reviews all waiver rule and policy changes.

   HFS and IDoA meet at least quarterly to review program administration and evaluate system performance. HFS conducts routine oversight monitoring of the fiscal and program activities to assure that the State meets the federal assurances identified in the waiver.

   There are two broad types of program reviews: record reviews and onsite provider reviews. HFS randomly selects the participant sample from the Medicaid Management Information System (MMIS) using claims for waiver services in a specific time period. The onsite provider reviews are more comprehensive than the record reviews. The onsite reviews assess how the waiver program operates overall reviewing components of participant eligibility, service plans, provider qualifications, health and safety, care coordination and how the system operates and communicates participant needs and issues.

   For MCOs, HFS and the state's External Quality Review Organization (EQRO) provide quality oversight and monitoring of the Waiver Providers through record review audits of the enrollee care plans for each Plan to monitor the quality of services and supports provided to the HCBS program Enrollees.

   The state's EQRO will be performing Record Reviews to evaluate compliance with waiver performance measures as well as certain contractual components. The tool evaluates the following waiver assurances:

   Level of Care—enrollee records are examined to determine completeness and accuracy of MMSE/DON completed by the Operating Agency (OA). The Plans are required to obtain a copy of the score of the current DON obtained by the OA upon enrollment.

   Qualified Providers—responsibility for provider enrollment remains with the OA. The MCOs are responsible to ensure an evaluation of the independent workers performance is completed annually, or according to the waiver requirements. Enrollee records are examined to determine the independent worker evaluation is

completed.

Additional EQRO oversight of the MCOs includes review of initial case manager/care coordinator qualifications and training, as well as ongoing annual training, and oversight of case manager/care coordinator caseloads during the post implementation review and during the administrative compliance reviews.

Service Plan Development—enrollee records are examined to determine that all assessed enrollee needs, goals, and risks are addressed in the service plan; services are provided according to the plan; service plans are signed and dated by the enrollee and case manager/care coordinator; enrollees are contacted by the case manager/care coordinator per applicable waiver requirements; service plans are updated when the enrollee's needs change; and that choice of services and providers was offered to the enrollee. Service plans are also reviewed for completeness, accuracy, and timeliness.

Health, Safety, and Welfare—enrollee records will be examined to determine that enrollees are aware of how and to whom to report abuse, neglect, and exploitation; and each enrollee with an independent worker has a backup plan.

Additional oversight of the MCOs critical incident (CI) processes is the responsibility of the MA and the EQRO. The MCOs submit a detailed monthly report of critical incidents to the MA and a quarterly summary report. The EQRO reviews the policies and procedures for each MCO for reporting CIs prior to accepting enrollment to ensure adequacy of tracking software and follow-up procedures. EQRO will review a sample of CI reports during the post implementation review and during the administrative compliance reviews.

Remediation—the EQRO will submit a report of findings to HFS at the conclusion of each onsite review. The report will consist of a summary of findings for each individual record reviewed, as well as a summary of overall findings detailed by Performance Measure and contractual requirements reviewed.

Remediation activities will be tracked by the EQRO to ensure 100% remediation of findings. Timeframes for completion of remediation will be reported in 30, 60, 90, or greater than 90 days. Remediation activities will be consistent with the approved activities detailed within each Performance Measure. HFS and EQRO will work collaboratively to follow up with the MCOs to ensure remediation occurs within the required time frames.

Sampling—the MA's sampling methodology is based on a statistically valid sampling approach that uses a 95% confidence level and a 5% margin of error.

MCOs are required to submit quarterly reports, using the format required by the MA, on specific performance measures, which are described in MA's contracts with the MCOs. For each performance measure, contracts specify numerators, denominators, sampling approaches, data sources, etc. The MA 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 MA in quarterly meetings.

MCO contracts include sanctions for failure to meet requirements for submissions of quality and performance measures.

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.:*

   Care Coordination Units (CCU): Care coordination services are performed by CCUs under the Operating Agency (IDoA). CCUs perform the initial and ongoing waiver eligibility determinations for both the FFS and Managed Care participants. For the Managed Care participants, the service planning and ongoing monitoring is the responsibility of the Managed Care entity.

CCU functions include:

1) Conduct a comprehensive care assessment of need and eligibility initially and at least annually or as needed based on changes in the participant's financial, support or functional needs.

2) Outline available services and choices and provide the participant with information to allow participant to make informed choices regarding services and providers.

3) Develop a plan of care with the participant that best meets participant needs, with available services through the waiver or other funding sources.

4) Monitor service implementation.

5) Maintain participant records.

Effective February 1, 2013, the state delivers care coordination and waiver services through a mandatory managed care delivery system for those waiver participants enrolled in the Integrated Care Program (ICP). The program was initially implemented in the Illinois areas of suburban Cook (all zip codes that do not begin with 606), DuPage, Kane, Kankakee, Lake and Will Counties. The state has implemented the managed care delivery system under the State plan authority [Section 1932(a)].

The ICP is a program for older adults and adults with disabilities, age 19 and over, who are eligible for Medicaid, but not eligible for Medicare. The Medicaid Agency (MA) contracted with two Managed Care Plans (Plans) to administer the program. Participants have the choice of Plans.

Subsequent to the initial rollout, the program expanded to the following counties: Winnebago, Boone, McHenry, Rock Island, Mercer, McHenry, Knox, Stark, Peoria, Tazewell, Logan, Menard, Sangamon, Christian, Macon, DeWitt, Mclean, Piatt, Ford, Champaign, Vermillion, Madison, St. Clair, Clinton and the City of Chicago.

Effective March 1, 2014, the delivery system expanded to include those participants whose waiver services are administered under the Medicare Medicaid Alignment Initiative (MMAI) for the dual eligible. For those who voluntarily enroll for MMAI, both Medicare and Medicaid covered services are covered and coordinated by the Health Plans. For those who are dual eligible, but opt not to participate in MMAI, the MA administers and provide waiver and other Medicaid covered services under a concurrent 1915b/c waiver. Managed Long-term Supports and Services (MLTSS) use the same Health Plans chosen to provide MMAI.

Services are designed in the similar manner as ICP. Eight Managed Care Organizations (Plans) were chosen by HFS for MMAI. Participants have the choice of six Plans in the greater Chicago region and two Plans in the Central Illinois region. The MMAI demonstration project provides coordinated care to more than 135,000 Medicare-Medicaid enrollees in the Chicagoland area and throughout central Illinois, including Champaign, Christian, Dewitt, Ford, Logan, Macon, McLean, Menard, Piatt, Sangamon and Vermillion counties.

For those waiver participants enrolled in an MCO, the Plans are responsible for care coordination, service plan development and implementation, participant safeguards, prior authorization of waiver services, utilization management, qualified provider enrollment, 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:
IDoA is responsible for oversight of the Care Coordination Units.

HFS, the Medicaid Agency, conducts routine monitoring of CCU performance by selecting a sample of participant files.

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

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

The data source for several measures includes customer satisfaction and quality of life surveys. MCOs are collecting this data either by evaluating 100 percent of records or through a representative sample of records, based on the specific performance measure.

MCOs are required to submit quarterly reports, using the format required by the MA, on specific performance measures, which are described in MA's contracts with the MCOs. For each performance measure, contracts specify numerators, denominators, sampling approaches, data sources, etc. The MA 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 MA in quarterly meetings. MCO contracts include sanctions for failure to meet requirements for submissions of quality and performance measures.

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

the required time frames.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The following describes the oversight of the Community Care Units (CCUs) and the Managed Care Organizations (MCO's).

Oversight of CCUs:

Quarterly:

IDoA aggregates and analyzes CCU performance data and produces management reports. These management reports help IDoA and the CCU identify potential performance problems for investigation and remediation. CCUs are required to use these reports as a central component of their own quality management strategy.

IDoA reviews reports with CCUs in joint meetings and individually as needed.
IDoA conducts calls with CCUs who perform poorly for two or more quarters to discuss corrective action strategies.

Annually:

IDoA conducts a desk audit of and conference call with each CCU. This audit includes a review of all performance reports, corrective action taken, and the policies and procedures maintained by the CCU.
Every three years:

IDoA conducts an onsite audit of each CCU that is a more extensive version of the desk audit.
All assessments and reviews may be done more frequently if needed. IDoA may conduct more frequent assessments or reviews based on a variety of reasons that may be the result of participant/family caregiver complaints, billing issues or an event report among others. These actions may occur if numerous event reports are received for same agency. IDoA may also conduct a Limited Scope QI onsite review or a Desk Audit. These actions are dependent upon the reasons that are triggering the need for a review.

HFS assesses the performance of the CCUs through comprehensive onsite reviews and statewide record reviews. HFS annually conducts comprehensive onsite provider reviews. A random sample of CCUs is drawn and then refined to ensure that CCUs with smaller caseloads are included. HFS makes sure that all regions are represented, and chooses two providers, usually one adult day service and one in-home care provider, serving participants whose care is coordinated by the CCU. Prior to the onsite reviews, HFS reviews IDoA records of critical events related to the CCU and providers; previous IDoA Quality Improvement and interim reviews conducted on the CCU and providers, including follow-up and actions taken. HFS documents previous IDoA findings to use to focus the onsite review and to verify corrective action steps and ongoing compliance. During the CCU performance review, HFS completes at least six record reviews and participant interviews. Timeliness and content of assessments, service plans and case notes are part of review of records. During participant interviews HFS validates that service plans meet participant needs, are person centered including evidence that participants know how to contact the Care Coordinator. HFS also reviews policies, event reports, and personnel records for evidence of compliance with qualifications and training. Lastly, HFS interviews administrative staff about quality assurance measures; complaint receipt and handling; and the process for reporting abuse or neglect.

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

Oversight of MCOs:

The State's Quality Improvement System (QIS) has been modified to assure that the MCO Plans are complying with

the federal assurances and performance measures that fall under the functions delegated to them by the MA. The sources of discovery vary, and the sampling methodology for discovery is based on either a 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 MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The MA pulls the sample annually and will adjust the methodology as additional MCOs are enrolled to provide long term services and supports.

Once the MA selects the sample, it is provided to the OA and to the MA's 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 then sends a report of findings to the MA and the MCOs. The MCOs are required to remediate findings within required timelines. The MCOs are to report remediation activities to the MA, 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 MA. These reports are to contain discovery and remediation activity and are reviewed at least quarterly. Data sources may include the Medicaid Management Information System, the MCOs' Information Systems, and the MCO's critical incident reporting systems and other data sources as indicated in the waiver.

The MA meets quarterly with the MCOs to assess 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 MA developed a performance measure to assure that the EQRO is completing the record reviews as required through their 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	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☐	☑	☐
Waiver enrollment managed against approved limits	☑	☑	☐
Waiver expenditures managed against approved levels	☑	☑	☐
Level of care evaluation	☑	☑	☑
Review of Participant service plans	☑	☑	☑
Prior authorization of waiver services	☐	☑	☑
Utilization management	☑	☑	☑
Qualified provider enrollment	☑	☑	☑
Execution of Medicaid provider agreements	☑	☑	☐
Establishment of a statewide rate methodology	☑	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑	☐
Quality assurance and quality improvement activities	☑	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
4A: # and % of overdue Individual Support Plans 12 month renewals that were remediated within 30 days by the MCO. N: # of overdue Individual Support Plan 12 month renewals which were remediated within 30 days by the MCO. D: Total # of MCO overdue Individual Support Plans 12 months renewals.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☑ **Other** Specify: MCO	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
7A:# and % of participant reviews conducted by the EQRO according to the sampling methodology specified in the waiver. N: # of participant reviews conducted by the EQRO according to the sampling methodology specified in the waiver. D: Total # 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☑ **Other** Specify: EQRO	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
8A:# and % of waiver service providers utilized by the MCO that are an enrolled Medicaid provider. N: # of enrolled certified waiver service providers utilized by the MCO that continue to meet applicable certification requirements. D: Total # of enrolled certified waiver service providers.

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

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

Data Aggregation and Analysis:

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

Performance Measure:
5A:# and % of individual findings regarding provider qualifications non-compliance that were remediated within 60 days by the MCO. N:# of individual findings regarding provider qualifications non-compliance that were remediated within 60 days by the MCO. D: Total # of individual findings regarding provider qualifications non-compliance.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports Case Manager Training

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

Data Aggregation and Analysis:

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

Performance Measure:
1A: The Interagency Agreement identifies responsibilities of the Medicaid agency and the operating agency, is on file at HFS, and is reviewed annually.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Interagency Agreement

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

Data Aggregation and Analysis:

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

Performance Measure:

6A:# and % of service plans that were implemented prior to authorization by the MCO with remediation within 60 days. N: # of service plans that were implemented prior to authorization by the MCO with remediation within 60 days. D: Total # of services plans reviewed by the MCO that were implemented prior to authorization.

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

Data Aggregation and Analysis:

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

	Specify:

Performance Measure:
3A: HFS exercises oversight of program administration by IDoA as indicated by: 1) regular management reports identifying status of the program in terms of the performance measures; 2) regular reports identifying remediation proposed or taken by the operating agency; 3) identification of trends indicating a need for follow up; 4) identification of promising practices and proposed improvements.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
2A: 100% of waiver program policies and procedures are reviewed by HFS, prior to implementation.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Medicaid agency, HFS, will conduct routine programmatic and fiscal monitoring for both the OA and the MCOs.

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

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

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

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

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS' contracts with Integrated Care Program MCOs that provide waiver services. Contract details regarding MCO performance measures include: numerators, denominators, sampling approaches, data sources, etc. The MA prescribes the reporting format for each MCO, providing 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 submit the reports on a quarterly basis to a SharePoint site at the MA. MA staff review reports to ensure all required information is included in the report, as well as to identify any performance issues requiring follow up with a particular MCO.
Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants enrolled in an MCO through consumer surveys and quarterly record reviews.

The MA's sampling methodology for the External Quality Review Organization (EQRO) quarterly record reviews has been finalized. The EQRO is the entity responsible for monitoring MCOs. HSAG, the MA's EQRO, will first determine the appropriate sample size for conducting sample by MCO and by Waiver, with Proportional random samples based on an individual MCO's waiver program distribution. Final sample size will be adjusted based on the actual MCO eligible population; MCO sample sizes will ensure a 95 percent confidence level and 5 percent margin of error. The MA will select samples by MCO and by Waiver.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
Quality Improvement reviews conducted by IDoA generally utilize either a 30 day or 60 day timeframe for completing corrective actions. Corrective actions which require no more than a 30 day remediation timeframe are generally those which would jeopardize the health, safety, and welfare of participants, such as lack of criminal background checks.

1A: The OA and MA will review the IA annually. If changes to the IA are needed, the OA and MA will draft amendment language within 30 days. The MA follows up to completion.

2A: The OA submits outstanding policies to the MA for approval. Remediation must be completed within 30 days. If remediation is not completed within 30 days, the OA reviews procedures and submits a plan of correction to the MA. The MA follows-up to completion.

3A: The OA submits outstanding policies to the MA for approval. Remediation must be completed within 30 days. If remediation is not completed within 30 days, the OA reviews procedures and submits a plan of correction to the MA. The MA follows-up to completion.

4A: The MCO conducts timely completion of the overdue Support Plans and renewals. The MCO may also provide training for case managers. Remediation must be completed within 30 days. If remediation is not completed within 30 days, the MCO reviews procedures and submits a plan of correction to the MA. The MA follows-up to completion.

5A: The MCO obtains provider qualifications documentation. The MCO will work with providers to obtain documentation. If not qualified, the provider is dis-enrolled and the MCO provides participant with other available providers. The MCO trains case managers, if needed. Remediation must be completed within 60 days. If remediation is not completed within 60 days, the MCO reviews procedures and submits a plan of correction to the MA. The MA follows-up to completion.

6A: The MCO provides training to case managers and authorizes service plans if appropriate. Remediation must be completed within 60 days. If remediation is not completed within 60 days, the MCO reviews procedures and submits a plan of correction to the MA. The MA follows-up to completion.

7A: The EQRO completes all outstanding case reviews and reviews the case review scheduling/process to determine reasons for reviews not being conducted. Remediation must be completed within 90 days. If remediation is not completed within 90 days, the EQRO reviews procedures and submits a plan of correction to the MA. The MA follows-up to completion.

8A: Upon discovery of non-compliance, the MCO is notified to change the provider. The MCO will work with providers and the OA to become an enrolled Medicaid provider. Training will be required for MCO case managers. Remediation must be completed within 60 days.

ii. Remediation Data Aggregation

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

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

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of 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
[x] Aged or Disabled, or Both - General					
	[x]	Aged	65		[x]
	[x]	Disabled (Physical)	60	64	
	[ ]	Disabled (Other)			
[ ] Aged or Disabled, or Both - Specific Recognized Subgroups					
	[ ]	Brain Injury			[ ]
	[ ]	HIV/AIDS			[ ]
	[ ]	Medically Fragile			[ ]
	[ ]	Technology Dependent			[ ]
[ ] Intellectual Disability or Developmental Disability, or Both					
	[ ]	Autism			[ ]
	[ ]	Developmental Disability			[ ]
	[ ]	Intellectual Disability			[ ]
[ ] Mental Illness					
	[ ]	Mental Illness			
	[ ]	Serious Emotional Disturbance			

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

1. Be an Illinois resident at time of service.
2. Be Medicaid eligible
3. Be at risk of nursing facility placement as measured by the Determination of Need (DON) assessment with a minimum score of 15 on functional impairment and a total of at least 29 points.

4. Ability to be maintained safely in the home at a cost which does not exceed the Service Cost Maximum as measured by the DON.

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:

Individuals who enter the waiver between the ages of 60 and 64 experience no discontinuity of service when they turn 65. Available services are the same for all waiver participants and are based on DON score not on age. After the age of 65 there is no maximum age limit for the waiver.

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.

Illinois uses the Determination of Need (DON) assessment tool for this waiver. The assessment tool was

developed by researchers at the University of Illinois Chicago. The original study that validated the DON was in 1983. A revalidation conducted in 1990's and described in the journal article, Pavez, G., Cohen, D, Hagopian, M, Prohaska, T., Blaser, C and Baruner, D.; A Brief Assessment Tool for Determining Eligibility and Need for Community-Based Long-Term Services; Behavior, Health, and Aging, Vol.1, No. 2, 1990; was a cooperative venture, which included the Department of Rehabilitation Services (now DHS-Division of Rehabilitation Services (DRS)), Department of Public Aid (now Department of Healthcare and Family Services (HFS)), and the Department on Aging (IDoA). The tool was developed for two purposes: 1) as a prescreening tool for level of care determinations for this waiver and nursing facilities and 2) as a tool to assess the level or services needed which equates to a Service Cost Maximum (SCM). The research analysis also identified ranges of DON scores and associated Service Cost Maximum (SCM) levels.

Upon administration of the DON, the methodology establishes a score. A minimum score of 29 points on the DON establishes the level of care eligibility to a nursing facility and the waiver program. The maximum score is 100. An individual point count on the DON is linked to a Service Cost Maximum (SCM). This methodology allows each individual Determination of Need score a specific Service Cost Maximum rather than a range of Determination of Need scores associated to one SCM.

The state may periodically up-date SCMs based on factors such as changes in provider rates or other factors that impact the cost of waiver services.

All waiver services except the installation of the Automated Medical Dispenser and the Emergency Home Response System are included in the Service Cost Maximum. However, the monthly rates are to be included.

Monthly Service Cost Maximums follow:

Homemaker Service:

DON SCORE SERVICE MAXIMUM LEVEL
29 $ 429
30 $ 480
31 $ 532
32 $ 583
33 $ 635
34 $ 686
35 $ 738
36 $ 789
37 $ 840
38 $ 892
39 $ 943
40 $ 995
41 $ 1,046
42 $ 1,097
43 $ 1,149
44 $ 1,200
45 $ 1,252
46 $ 1,303
47 $ 1,355
48 $ 1,406
49 $ 1,457
50 $ 1,509
51 $ 1,560
52 $ 1,612
53 $ 1,663
54 $ 1,714
55 $ 1,766
56 $ 1,817
57 $ 1,869
58 $ 1,920
59 $ 1,972
60 $ 2,023
61 $ 2,074

62 $ 2,126
63 $ 2,177
64 $ 2,229
65 $ 2,280
66 $ 2,332
67 $ 2,383
68 $ 2,434
69 $ 2,486
70 $ 2,537
71 $ 2,589
72 $ 2,640
73 $ 2,691
74 $ 2,743
75 $ 2,794
76 $ 2,846
77 $ 2,897
78 $ 2,949
79 $ 3,000
80 $ 3,051
81 $ 3,103
82 $ 3,154
83 $ 3,206
84 $ 3,257
85 $ 3,309
86 $ 3,360
87 $ 3,411
88 $ 3,463
89 $ 3,514
90 $ 3,566
91 $ 3,617
92 $ 3,668
93 $ 3,720
94 $ 3,771
95 $ 3,823
96 $ 3,874
97 $ 3,926
98 $ 3,977
99 $ 4,028
100 $ 4,080

Adult Day Service:
DON SCORE SERVICE MAXIMUM LEVEL
29 $ 661
30 $ 769
31 $ 884
32 $ 998
33 $ 1,113
34 $ 1,227
35 $ 1,297
36 $ 1,366
37 $ 1,435
38 $ 1,505
39 $ 1,574
40 $ 1,644
41 $ 1,713
42 $ 1,783
43 $ 1,853
44 $ 1,922
45 $ 1,992
46 $ 2,061
47 $ 2,131
48 $ 2,200

49 $ 2,269
50 $ 2,339
51 $ 2,408
52 $ 2,478
53 $ 2,547
54 $ 2,616
55 $ 2,686
56 $ 2,755
57 $ 2,825
58 $ 2,894
59 $ 2,964
60 $ 3,033
61 $ 3,102
62 $ 3,172
63 $ 3,241
64 $ 3,311
65 $ 3,380
66 $ 3,450
67 $ 3,520
68 $ 3,589
69 $ 3,659
70 $ 3,728
71 $ 3,798
72 $ 3,867
73 $ 3,936
74 $ 4,006
75 $ 4,075
76 $ 4,145
77 $ 4,214
78 $ 4,284
79 $ 4,353
80 $ 4,422
81 $ 4,492
82 $ 4,561
83 $ 4,631
84 $ 4,700
85 $ 4,770
86 $ 4,839
87 $ 4,908
88 $ 4,978
89 $ 5,047
90 $ 5,117
91 $ 5,186
92 $ 5,256
93 $ 5,326
94 $ 5,395
95 $ 5,465
96 $ 5,534
97 $ 5,604
98 $ 5,673
99 $ 5,742
100 $ 5,812

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:

Upon receipt of federal approval, the OA will implement the new Service Cost Maximum methodology as indicated below.

The installation of the AMD and the EHRS are not included in the Service Cost Maximum, however, the monthly rates are included.

The new methodology establishes Service Cost Maximums based on individual Determination of Need scores, instead of a range of scores. The result is that each individual Determination of Need score has a specific Service Cost Maximum rather than a range of Determination of Need scores linking up to one Service Cost Maximum.

In order to address any participants that may be negatively impacted, the State has established a transition plan. The transition plan is outlined in Attachment A and was approved by CMS, prior to submitting this amendment.

SCMs may be updated in the future based on proposed increases in provider rates or other factors that impact the cost of waiver services.

Monthly Service Cost Maximums follow:

Homemaker Service:
DON SCORE SERVICE MAXIMUM LEVEL

29 429
30 480
31 532
32 583
33 635
34 686
35 738
36 789
37 840
38 892
39 943
40 995
41 1,046
42 1,097
43 1,149
44 1,200
45 1,252
46 1,303
47 1,355

48 1,406
49 1,457
50 1,509
51 1,560
52 1,612
53 1,663
54 1,714
55 1,766
56 1,817
57 1,869
58 1,920
59 1,972
60 2,023
61 2,074
62 2,126
63 2,177
64 2,229
65 2,280
66 2,332
67 2,383
68 2,434
69 2,486
70 2,537
71 2,589
72 2,640
73 2,691
74 2,743
75 2,794
76 2,846
77 2,897
78 2,949
79 3,000
80 3,051
81 3,103
82 3,154
83 3,206
84 3,257
85 3,309
86 3,360
87 3,411
88 3,463
89 3,514
90 3,566
91 3,617
92 3,668
93 3,720
94 3,771
95 3,823
96 3,874
97 3,926
98 3,977
99 4,028
100 4,080

Adult Day Service:
DON SCORE SERVICE MAXIMUM LEVEL
29 661
30 769
31 884
32 998
33 1,113
34 1,227

35 1,297
36 1,366
37 1,435
38 1,505
39 1,574
40 1,644
41 1,713
42 1,783
43 1,853
44 1,922
45 1,992
46 2,061
47 2,131
48 2,200
49 2,269
50 2,339
51 2,408
52 2,478
53 2,547
54 2,616
55 2,686
56 2,755
57 2,825
58 2,894
59 2,964
60 3,033
61 3,102
62 3,172
63 3,241
64 3,311
65 3,380
66 3,450
67 3,520
68 3,589
69 3,659
70 3,728
71 3,798
72 3,867
73 3,936
74 4,006
75 4,075
76 4,145
77 4,214
78 4,284
79 4,353
80 4,422
81 4,492
82 4,561
83 4,631
84 4,700
85 4,770
86 4,839
87 4,908
88 4,978
89 5,047
90 5,117
91 5,186
92 5,256
93 5,326
94 5,395
95 5,465
96 5,534

97 5,604
98 5,673
99 5,742
100 5,812

Appendix B: Participant Access and Eligibility

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

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:

A comprehensive needs assessment tool is used to determine participant's goals, risks, needs and preferences for services. The assessment looks at the participant's situation and circumstances related to all factors contributing to health, safety, well-being, quality of life and the ability to live independently in the community. It includes a review of the participant's environment in the community, as well as the participant's physical, cognitive, psychological, and social well-being.

The comprehensive assessment tool covers 11 domains: participant demographics, functional impairments [Determination of Need (DON) and Mini-Mental State Exam (MMSE)], physical health history and assessment, behavioral health (including spirituality), medications, nutritional screening, caregiver, transportation, environment, financial and legal status. The assessment also includes identification of existing support systems and the need for further evaluation by other disciplines.

The person centered plan of care that is developed based upon the assessment, identifies all services, the need for additional evaluation(s), participant expressed goals, needs and wants, and service arrangements. It also includes identification of service needs being met by existing support systems including public, private, family and community and those funded by other than the Community Care Program (waiver services). Care coordinators are encouraged to use grant funded services when available to assist in meeting participants' needs and fill-in gaps where traditional CCP services are not available or adequate.

If an individual does not meet eligibility requirements, IDoA sends the individual a Client Action Notice that informs the individual why he or she is not eligible. The notice also includes a statement that if the person does not agree with this planned action, that individual can appeal the Client Action Notice and request a hearing. The notice explains how to request an appeal with the appropriate forms enclosed. All services in effect at the time of the appeal will continue until the decision of the appeal is issued. Section F-1 describes the Fair Hearing Process in more detail.

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.**
- [x] **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:

Temporary Service Increase (TSIs) refers to an assessment type that is completed when a current participant is at imminent risk of entering a nursing facility. Care Coordinators complete a new DON and use the appropriate service cost maximum to authorize a level of services based on the current needs of the participant. The benefit of a TSI is that due to the imminent risk of nursing home placement the new or increased level of services are expedited and are required to be implemented within two days. Care Coordinators are required to complete follow-up and thorough assessment within specified timeframes for participants that have had a TSI assessment. If the TSI was completed while the participant was in the hospital, the complete assessment must be completed within 15 calendar days. If the TSI was completed while the participant is residing in the community, the complete assessment must be completed within 30 days. At the time of the complete reassessment, a new DON is completed and services are established based on service needs identified at that time.

- [ ] **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	79090
Year 2	92054
Year 3	105618
Year 4	122447
Year 5	143101

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:

There are no specific policies related to prioritization of waiver services or applications. Persons that meet eligibility requirements are enrolled in the waiver upon completion of the waiver application. There is no waiting list for services.

For those individuals who are enrolled in MCOs, State-established policies governing the selection of individuals for entrance to the waiver remain the same as for all participants. Initial waiver eligibility is be conducted by the State contracted Community Care Units (CCUs), who are the same entities providing care coordination on behalf of the waiver participants not enrolled in a MCO. The CCUs use the same objective criteria for all participants. 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**
- [x] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

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

Specify percentage:

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

The state proposes to add:

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.

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 spenddown 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 five-year period beginning January 1, 2014, 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 December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (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. 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 the waiver participants equals the maximum income an individual can have and be eligible under 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 (see instructions)**
- **The following standard under 42 CFR §435.121**

  Specify:
- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

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

The amount is determined using the following formula:

Specify:

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

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

Other

Specify:

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

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

Select one:

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

The State does not establish reasonable limits.

The State establishes the following reasonable limits

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Answers provided in Appendix B-5-a 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 (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.

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. 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 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 (see instructions)**
- **The following standard under 42 CFR §435.121**

  Specify:

- **Optional State supplement standard**
- **Medically needy income standard**
- **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- **The amount is determined using the following formula:**

  Specify:

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

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

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

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

Specify:

- **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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:

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-6: Evaluation/Reevaluation of Level of Care

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

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

   i. **Minimum number of services.**

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

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

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

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

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

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

   Specify the entity:

   - **Other**

   Specify:

   The CCU is responsible for performing evaluations and reevaluations.

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:

   Minimum qualifications for care coordinators:
   1)Be an R.N, or have a B.S.N, or have a B.A./B.S. 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 LPN with one year of program experience which is defined as assessment of a provision of formal services for the elderly and /or authorizing service provision; or
3)Be waived for persons hired/serving in this capacity prior to December 31, 1999.

Care coordinators must also complete the following IDoA sponsored training:
1)Preliminary Community Care Program (CCP) training which must occur prior to conducting participant assessments;
2)CCP Certification training and successfully pass the required exam within six months of completing Preliminary training; and
3)Recertification training within each 18-month anniversary of each previous certification.

Care coordinators must also complete 18 hours of documented in-service training on aging related subjects within each calendar year. For partial years of employment, training is prorated to equal 1.5 hours for each full month of employment.

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 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 into 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 (DON). Those individuals identified through the screening process as needing nursing facility level of care are afforded the opportunity to select a supportive living facility 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 (IL-402-1230).

In order to be eligible for waiver services, the participant must be evaluated with the Illinois Determination of Need (DON) assessment and receive at least 15 points on functional impairment and a total of 29 points. This assessment includes a Mini-Mental State Exam (MMSE) and a functional level of needs and unmet needs section. The functional status section assesses both activities of daily living (ADL) and instrumental activities of daily living (IADL). The functional areas are: eating, bathing, grooming, dressing, transferring, incontinence, managing money, telephoning, preparing meals, laundry, housework, outside of home, routine health, special health, and being alone. Each area is scored 0 - 3 for level of need, and 0 - 3 depending on the level of natural supports available to meet the need. The score of 0 is no need increasing up to total dependence with a score of 3. Mental status is evaluated using the standardized MMSE. Care coordinators receive training and guidelines for scoring each area consistently. The DON is the same criteria used to assess for nursing facility eligibility. The final score is calculated by adding the results of the MMSE, the level of impairment and the unmet need.

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

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

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

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating

waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The CCUs conduct the level of care evaluations and reevaluations utilizing the Determination of Need as described above.

For participants enrolled in an MCO, the re-evaluations are conducted by the OA.

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

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

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

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

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

CCU care coordinators enter participant demographic and assessment information into the relational computerized database, Case Management Information System (CMIS). The CMIS offers one method used by the CCUs to ensure the timely reevaluation.

The CMIS generates standard reports, which also assist the CCUs as a participant tracking and caseload management system. Care coordination activities are managed by maintaining care plans and producing reports that provide care coordinators with a reminder of participant assessment due in given month. The care coordinator supervisors use the standard reports to monitor and evaluate care coordinator activities, and include current month assessment status, up-coming assessments and case management projections.

Partcipant assessment information is transmitted via CMIS to the IDoA's Internet based billing system, electronic CCP Information System (eCCPIS). CCU's periodically review the eCCPIS, to run the redetermination due or overdue report to prevent untimely annual redeterminations.

The eCCPIS reports are available to the CCUs to track when annual eligibility determinations are due. IDoA encourages the CCUs to review the eCCPIS on a regular schedule. IDoA staff review eCCPIS redetermination due reports at least twice a year.

IDoA and HFS monitor timeliness of reevaluations during monitoring activities.

For participants enrolled in an MCO, the OA will employ procedures to ensure its timely reevaluations of level of care.

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 State requires that CCUs adhere to IDoA's standards and policies which requires that all written and/or electronic

documentation related to all evaluations, reevaluations and participant care are maintained for a minimum period of 6 years after the contract terminates under which the participant was served. Active participant's records can never be purged regardless of contract termination dates. CCUs are required to maintain records in a secure, confidential location that is readily accessible during this period.

For participants enrolled in an MCO, the Plans will maintain the forms. The record retention requirements will be the same for the MCOs as it is for the fee-for-service enrollees. As required by CMS, the minimum is three years.

The record retention requirements will be the same for Managed Care enrollees as it is for the Fee-for-Service (FFS) enrollees. As required by CMS, the minimum will be three years.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
9B: The Care Coordinator completes a waiver application (that includes a level of care determination) for all persons that apply for the HCBS waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Community Care Program Time Frames Report

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

		Sample Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
11B: Level of care reviews are completed on or before the annual review date.

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

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

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

		Sample Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
10B: All eligibility determinations will be finalized within 30 days of receipt of a completed application for CCP using the DON.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
11B - 2: Number and percentage of waiver participants' data reviewed to ensure agreement with approved projected waiver capacity. N: Total participant enrollment data reviewed for each quarter. D: Annual projected total enrollment

data for the waiver year.

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

	☑ **Other** Specify: Report data to federal CMS quarterly

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:
12B: No person will be eligible for the program with a DON impairment score of less than 15 and a minimum total score of 29.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Event Reports

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

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

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

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

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

		Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Care Coordination Units (CCUs) conduct Level of Care (LOC) determinations. The state has a two-pronged approach to ensuring that LOC determinations are done in an accurate and timely fashion.

First, IDoA requires each CCU to maintain written and up-to-date policies for ensuring that all individuals potentially eligible for the waiver are given the opportunity to apply. CCUs must submit these policies to IDoA on an annual basis. IDoA reviews these policies using a checklist tool and aggregates the results in an Access database. IDoA also conducts reviews once every three years to ensure that the CCUs are following their written policies.

Second, the state maintains tracking databases in which the CCUs enter information about individual LOC determinations. These databases contain individual level and item level information from the LOC

determination tools. Information is collected on a continuous basis. IDoA extracts information from these databases regarding the timeliness of the eligibility determinations and redeterminations. The information is summarized in quarterly management reports. The databases also contain edits that ensure that only individuals who meet the LOC eligibility threshold are determined eligible for the program.

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

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

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS' contracts with Integrated Care Program MCOs that provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc. Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants enrolled in an MCO through consumer surveys and quarterly record reviews. Participants in MCOs are included in the representative sampling.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
9B: Application is completed upon discovery. Remediation must be completed within 60 days.

10B: Eligibility determinations will be completed upon discovery. Remediation must be completed within 60 days.

11B: Remediation: 1. LOC is completed upon discovery. 2. If eligible, no additional correction required. 3. If ineligible, billing and claims are adjusted. 4. Individual receives assistance with accessing other supports and services. Remediation must be within 60 days.

13B: If it is discovered that the impairment score is less than 15 and/or the minimum total score is less than 29, the OA will require a justification case managers for the eligibility determination. If the justification is inadequate, the waiver eligibility will be discontinued and the OA will assist the individual with accessing other supports and services. Federal claims will be adjusted and the OA will provide technical assistance or training to case managers. Remediation must be completed within 60 days.

ii. Remediation Data Aggregation

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

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

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Participant choice is a requirement of the CCP Administrative Rule 240.330. Upon assessment, participants are offered the choice between waiver services and institutional care. Care coordinators discuss service options including institutionalized care and ensure that the participant is fully aware of the pros and cons of each option. The participant must sign the form verifying that choice of setting was given. This same statement is also on the CCP form and participants verify by signature at the time of initial assessment that they were offered a choice of services versus institutional care. Freedom of choice is also discussed in the Rights and Responsibilities brochure that is given-out to participants at each assessment. Care coordinators are required to show evidence of the participant's acknowledgement of receipt of the brochure in his/her documentation in the case notes.

Once a participant chooses to have CCP services, he or she is given a choice of provider agency (ies). Care coordinators are trained to educate participants and provide an informed choice on the available providers, their settings if service is to be delivered outside of the home, and to assist participants, if needed. IDoA utilizes a Vendor Selection Form (VSF), which the participant signs, to document participant preference of providers. If a participant has no preference, then each CCU is required to maintain a provider selection rotation list from which a care coordinator will assign a provider to a participant based on the rotation list. When a participant wishes to change providers, a new VSF can be completed and providers will be switched within fifteen days of finalizing the paperwork.

For participants enrolled in an MCO, preference for institutional or home and community-based services is documented on a Freedom of Choice form provided by the Plan and approved by the MA. The participant must sign the completed form indicating his/her choice and that he/she has made an informed decision.

MCOs are required to enter into contracts with a sufficient number of such providers within each county in the contracting area. Similar to CCU expectations, MCO care coordinators are trained to educate participants and provide an informed choice on the available providers and description of HCBS setting, if service is to be delivered outside of the home. For persons who do not express a choice amongst available contracted providers, the Plan shall fairly distribute such participants, taking into account all relevant factors, among those providers who are willing and able to accept the participant and who meet applicable quality standards.

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.

The State requires that CCUs adhere to the Department's standards and policies which requires that all written and/or

electronic documentation related to all evaluations, reevaluations and participant care are maintained for a minimum period of 6 years after the contract terminates under which the participant was served. Active participant's records can never be purged regardless of contract termination dates. CCUs are required to maintain records in a secure, confidential location that is readily accessible during this period.

For participants enrolled in an MCO, the Plans are to maintain the 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):
The State provides access to waiver services to all eligible seniors in Illinois including Limited English Proficient persons. The State provides assessment forms, brochures, and applicable paperwork that have been translated in 16 different languages to the Care Coordination Units for use. Many Care Coordination Units have bilingual Care Coordinators to perform assessments on non-English speaking clients. The State also requires that Care Coordinators use translators when necessary to complete assessments and provide care coordination services. The State reimburses the Care Coordination Units at a higher rate when a translator is required. The State also has provider agencies that target specific ethnic populations and therefore have workers that are fluent in specific languages. This information is provided to the participants during the assessment so that the participants can make an informed choice about the provider they chose. Emergency Home Reponse System (EHRS) provider standards require providers to utilize translation services that are capable of communicating in 144+ languages. The State also has arranged for technical assistance for providers through The Coalition of Limited English Speaking Elderly (CLESE) to help them through the provider application process, billing and payment issues.

For participants enrolled in an MCO, the Plan provide written materials distributed to English speaking enrollees, as appropriate, available in Spanish and other prevalent languages, as determined by the MA. Where there is a prevalent single-language minority within the low income households (5% or more such households) where a language other than English is spoken, the Plans' written materials must be available in that language as well as in 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		
Statutory Service	Adult Day Service		
Statutory Service	In-home Service		
Other Service	Automated Medication Dispenser (AMD)		
Other Service	Emergency Home Response Service		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Service

HCBS Taxonomy:

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

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (selected) **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Adult Day Service is the direct care and supervision of adults aged 60 or over, in a community-based setting for the purpose of providing personal attention; and promoting social, physical and emotional well being in a structured setting. Required service components include:

Assessment of the participant's strengths and needs and development of an individual written plan of care for each participant that establishes specific goals for all service components to be provided or arranged by the service provider.

The individual plan of care is to be established by the adult day service team consisting of program coordinator/director and program nurse, and may include other staff at the option of the program coordinator/director.

The individual plan of care shall address the needs identified by the Case Coordination Unit (CCU) as described in the Determination of Need (DON), Client Agreement-Plan of Care and approved by the client's physician/nurse practitioner/registered nurse/Christian science practitioner.

The individual plan of care shall address the need identified by the service provider's staff and participant/caregiver during the individualized plan of care process.

The participant, caregiver, and other service providers shall have the opportunity to contribute to the development, implementation, and evaluation of the individualized plan of care.

Reassessing the participant's needs and reevaluating the appropriateness of the individualized plan of care shall be done as needed, but at least semi-annually.

A balance of purposeful activities to meet the participant's interrelated needs and interests (social, intellectual, cultural, economic, emotional, physical, and spiritual) designed to improve or maintain the optimal functioning of the participant.

Activity programming shall take into consideration individual differences in age, health status, sensory deficits, lifestyle, ethnicity, religious affiliation, values, experiences, needs, interests and abilities by providing for a variety of types and levels of involvement.

Time for rest and relaxation shall be provided as needed or prescribed.

Activity opportunities shall be available whenever the service provider's facility is in operation and participants are in attendance.

A monthly calendar of activities of daily living shall be prepared and posted in a visible place.

Assistance with or supervision of activities of daily living (e.g., walking, eating, toileting, and personal care) as needed.

Provision of health-related services appropriate to the participants needs as identified in the provider assessment and/or physician's orders, including health monitoring, nursing intervention on a moderate or intermittent basis for medical conditions and functional limitations, medication monitoring, medication administration or supervision of self-administration, and coordination of health services.

A meal at mid-day meeting a minimum of one-third of the Dietary Reference Intakes (DRI) as established by the Food and Nutrition Board of the National Academy of Sciences, 10th Revised Edition, 2006, no further amendments or editions included. Supplementary nutritious snacks and special diets shall also be provided as directed by the client's physician.

Agency provision or arrangement of transportation, with at least one vehicle physically accessible, to enable clients to receive adult day care service at the adult day care service provider's site and participate in sponsored outings. The adult day care transportation is billed as a separate service component.

Provision of emergency care as appropriate in accordance with established adult day care service providers' policies and IDoA rules.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services are provided according to the plan of care within the service cost maximum

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Service

Provider Category:
Agency
Provider Type:
Adult Day Care
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
89 Ill. Admin. Code 240

Verification of Provider Qualifications

Entity Responsible for Verification:
IDoA

Frequency of Verification:
At time of enrollment and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Homemaker

Alternate Service Title (if any):
In-home Service

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services consisting of general household activities (meal preparation and routine household care) provided by a trained homecare aide, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homecare aides shall meet such standards of education and training as are established by the State for the provision of these activities.

In-home serivce is defined as general non-medical support by supervised homecare aides who receive specialized

training in the provision of in-home services. The purpose of providing in-home services is to maintain, strengthen, and safeguard functioning of individuals in their own homes in accordance with the authorized plan. Specific components of in-home services shall include the following:

Teaching/performing of meal planning and preparation; routine housekeeping skills/tasks (e.g. making and changing beds, dusting, washing dishes, vacuuming, cleaning and waxing floors, keeping the kitchen and bathroom clean and laundering the participant's linens and clothing); shopping skills/tasks; and home maintenance and repairs.

Assisting with self-administered medication which shall be limited to:

· Reminding the participant to take his/her medications;
· Reading instructions for utilization;
· Uncapping medication containers; and,
· Providing the proper liquid and utensil with which to take medications.

Performing/assisting with essential shopping errands may include handling the participant's money (proper accounting to the participant of money handled and provision of receipts are required). These tasks shall be:
· Performed as specifically required by the plan of care; and,
· Monitored by the in-home service supervisor.

Assisting with following a written special diet plan and reinforcement of diet maintenance (can only be provided under the direction of a physician and as required in the plan of care).
Observing client's functioning and reporting to the supervisor.
Performing/assisting with personal care tasks (e.g.: shaving, hair shampooing and combing; bathing and sponge bath, shower bath or tub bath; dressing; brushing and cleaning teeth or dentures and preparation of appropriate cleaning supplies; transferring participant; and assisting participant with range of motion.

Escort to medical facilities, errands, shopping and individual business as specified in the plan of care.

In-home services may include transportation to medical facilities, or for essential errands/shopping, or for essential participant business with or on behalf of the participant as specified in the plan of care.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Service is limited by the service cost maximum, except for transport. There is a maximum of 100 hours hours a month.

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Homemaker Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: In-home Service

Provider Category:
Agency

Provider Type:
Homemaker Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
89 Ill Admin Code 240
Verification of Provider Qualifications
Entity Responsible for Verification:
IDoA
Frequency of Verification:
At time of enrollment and every three years

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:
Automated Medication Dispenser (AMD)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Automated Medication Dispenser service (AMD) is defined as "a portable, mechanical system for individual use that can be programmed to dispense or alert the participant to take non-liquid oral medications in the participant's residence or other temporary residence in Illinois through auditory, visual or voice reminders; to provide tracking and caregiver notification of a missed medication dose; and to provide 24 hour technical assistance to the participant and responsible party for the AMD service in the home. The service may provide additional medication specific directions, or prompts to take medications via other routes such as liquid medications or injections based on individual need.

The purpose of the service is to provide the participant with medication reminders when mild cognitive deficits or severe physical limitations prevent timely and safe administration of a complex medication schedule thereby promoting independence and safety of the participants in their own homes as well as potentially reducing the need for nursing home care.
The authorization of the service is determined by the Care Coordinator through a screening of the participant's medication, medical, cognitive and physical needs; potential to benefit; availability of a willing and reliable responsible party(s) to manage medications; and commitment to use the system appropriately. The service must be authorized in the person-centered plan of care.

This service does not include Department or AMD provider medication management, oversight or handling of the participant's medications. The participant or responsible party must be responsible for managing the acquisition of all prescribed medications, including assuring the medications are administered according to physician orders, and must manually fill the AMD. The participant or responsible party is to work with the AMD provider to program the dispenser initially and to reprogram the dispenser with any changes in the medication schedule.

In addition, the participant must have a willing family member/responsible party to be the point of contact and to act on AMD provider notification of missed medication doses and other system issues such as power outages. The service is provided by a standalone medication dispenser base unit that is connected to and supported by a Department approved AMD provider through either the telephone line or wireless/cellular system. Electronic data on the following information is transmitted and maintained by the provider including, but not limited to: missed medication doses, notification of the responsible party when medication doses are missed, power outages or other system defaults are detected and disposition of notifications. The data will be available via electronic reports on an individual basis to the responsible party (ies) and care coordinators and in the individual or aggregate to the operating agency for the oversight of adherence to medication schedules and quality management improvement activities.

The state offers this service through the Request for Certification to assure that any willing and qualified providers have the opportunity to provide this service. Through the Request for Information and informal contacts with providers of this service, it is believed that the vast majority of providers also provide emergency home response (EHRS) services. Standards have been written to identify required automated medication dispenser service components, minimum equipment specifications and administrative requirements.

The one-time installation is separate from the monthly rental and service cost. The one-time installation cost may be combined with installation of an emergency home response system if installed at the same time by the same provider. The installation rate covers the following: maintaining adequate local staffing levels of qualified personnel to service necessary administrative activities, installation, and in-home training. The monthly rental and service rate covers the following: maintaining administrative and technical support to program machines, provide 24 hour technical assistance, signal monitoring, troubleshooting, providing machine maintenance and repair requests, sending notifications on missed medication doses and providing reports.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount, duration and scope of service is based on the determination of need assessment conducted by the care coordinator and the service cost maximum determined by the DON score

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- [x] **Legally Responsible Person**

☑ **Relative**

☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Automated Medication Dispenser Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Automated Medication Dispenser (AMD)

Provider Category:
Agency

Provider Type:
Automated Medication Dispenser Provider

Provider Qualifications

License *(specify):*
None

Certificate *(specify):*
None

Other Standard *(specify):*
As specified in the IDoA Community Care Program Standards for Automated Medication Dispenser Services. This document will be posted on the IDoA website.

Provider standards are in administrative rule. Providers must meet the standards as specified in Title 89 Section 240 or the Illinois Administrative Code.

Verification of Provider Qualifications

Entity Responsible for Verification:
IDoA

Frequency of Verification:
At time of enrollment, upon renewal every three years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Emergency Home Response Service

HCBS Taxonomy:

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

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Emergency home response service (EHRS) is defined as a 24-hour emergency communication link to assistance outside the participant's home for participants based on health and safety needs and mobility limitations. This service is provided by a two-way voice communication system consisting of a base unit and an activation device worn by the participant that will automatically link the participant to a professionally staffed support center. The support center assesses the situation and directs an appropriate response whenever this system is engaged by a participant. The purpose of providing EHRS is to improve the independence and safety of participants in their own homes in accordance with the authorized plan of care, and thereby help reduce the need for nursing home care.

Services cover both initial one time installation and monthly rental costs.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount, duration and scope of services is based on the determination of need assessment conducted by the care coordinator and the service cost maximum determined by the DON score.

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

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

Specify whether the service may be provided by *(check each that applies)***:**
- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergency Home Response Service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Emergency Home Response Service

Provider Category:
Agency
Provider Type:
Emergency Home Response Service
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
As specified in IDoA Community Care Program Standards for Emergency Home Response Services. This document can be found at http://www.state.il.us/aging/1athome/awaq/EHRS_standards.pdf

Provider standards are in administrative rule. Providers must meet the standards as specified in Title 89 Section 240 of the Illinois Admin. Code.

Verification of Provider Qualifications

Entity Responsible for Verification:
IDoA

Frequency of Verification:
At time of enrollment and annually

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.*

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

Care Coordination Units (CCUs) contracted by IDoA provide care coordination services.

For participants enrolled in an MCO, case management will be the responsibility of the Plans.

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):

All direct service workers including homecare aide and Adult Day Service employees, must have criminal background checks in accordance with the Health Care Worker Background Check Act. Requests for a health care worker background check are statewide in scope and are processed by the Illinois State Police.

Providers are responsible to complete the background check, maintain information in the employee file, and enter verification in a training tracking database or documentation in a personnel file. IDoA audits for compliance with this requirement when completing quarterly management reports, during the provider audit, and the documentation is verified during the onsite reviews.

During routine monitoring HFS reviews agency policies and employee files for evidence that criminal background checks are conducted.

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):

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).**

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.*

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.*

Each homecare provider agency has established an agency-specific policy regarding the hiring and assignment of homecare workers to participants who are family members. The policy must include the State policy and procedures for Family Members as Homecare Workers and must specify the circumstances under which the homecare worker shall be allowed to service family members as well as circumstances which would preclude such an assignment. Circumstances that may allow a family member to provide direct care services can include language barriers or worker availability.

The State will pay relatives to provide in-home services under specific conditions. This condition is the relative cannot be a legally responsible person to the applicant/participant, i.e. spouse, guardian, person(s) with Power of Attorney or representative payee.

Care coordinators refer interested family members to the participant’s chosen homecare provider. When developing the service plan, care coordinators will only schedule evening/weekend services based on participant's needs, not to accommodate family member availability. Family members hired as homecare workers cannot be an applicant/participant's authorized representative and may not sign the Client Agreement, Vendor Selection or Eligibility form.

Homecare providers must provide documentation substantiating the reason for hiring the family member. Providers must report the assignment of the family member and his or her relationship to the participant to the CCU; both the provider and the CCU keep documentation of the notification. Providers conduct more intensive monitoring/supervision of family members including at a minimum monthly phone monitoring during hours of service to ensure the homecare worker is there and accurately reporting hours worked and quarterly unannounced visits to ensure the homecare worker is following the plan of care.

- **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:

In order for a waiver service provider to be qualified to enroll, the provider must be certified to provide Community Care Program (CCP) services. The Illinois Department on Aging (IDoA) certifies service providers through an application process. Applications may be submitted at any time. Provider applications are available on the IDoA website. Provider standards exist for each service type, which must be met before certification is approved. Certification includes an IDoA review of the service provider application for administrative requirements and applicable required documentation, a site review of the physical location, and completion of a required management-training course. Other factors which may influence the certification decision include: pending or current IDoA or other governmental entity sanctions; a history of non-compliance; legal notification of financial insolvency, criminal indictment or conviction; or other legal issues, which would make the award contrary to the best interests of the state or the program. Provider applicants may object to the certification decision by providing written notification to IDoA on or before the tenth calendar day from the date of the applicant's receipt of the written notification. IDoA notifies HFS as the SMA of any changes to the Purchase of Service Agreement template and HFS reviews and approves the changes.

For administrative purposes, IDoA awards Purchase of Service Agreements semi-annually. Provisions are made to expedite the application approval process when necessary to ensure access to needed services.

In the first year, Plans are required to contract with any willing and qualified providers currently approved to provide waiver services. Qualifications may be enhanced by the Plans.

The State will institute an "any willing provider" contractual clause that will require Plans to offer contracts to any willing provider that meets quality and credentialing standards. After the initial contracting period, Plans will be allowed to impose a known quality standard and to terminate contracts with underperforming providers. In addition to this any willing provider standard, Plans must continually meet the following network adequacy requirements throughout the term of their contracts.

For each of the following HCBS waiver services, Plans must contract, on a county-by-county basis, with a network of providers that are currently serving in aggregate at least 80 percent of current clients in the fee-for-service system. In counties where there is more than one service provider, Plans must contract with at least two providers, even if one provider serves more than 80% of current clients. In counties where there is no current service provider, Plans must contract with the providers in other counties who, in the aggregate, currently provide at least 80% of the services to clients in that county.

Adult Day Care
Homemaker

The State determined the network adequacy requirements based on an analysis of the number of providers in each county and the percentage of current beneficiaries receiving services from each provider. The State determined that an 80 percent standard will require Plans to contract with the majority of providers in a region and ensures a network with more than adequate capacity to serve 100% of Plan enrollees. In addition, the State feels an 80 percent standard aligns with federal assumptions regarding the number of dual eligible beneficiaries who will opt out of the financial alignment demonstration. In the ICP program, the 80% standard far exceeds the percentage of waiver participants enrolled in ICP.

Personal Emergency Response System: Plans must contract with at least two providers in the region.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
13C: Each In-Home Service, ADS and AMD provider meets State requirements at the time of the initial contract approval and on an ongoing basis by demonstrating compliance with State regulation and contract provisions for providing services to participants in the Community Care Program.

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

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
14C: Each CCU meets State requirements at the time of the initial contract approval and on an ongoing basis by demonstrating compliance with State regulation and contract provisions for providing care coordination to participants in the Community Care Program.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Annual Contract Review Checklist

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
16C:# and % of case managers who meet waiver provider training requirements. N: # of MCO case managers reviewed who meet waiver provider training requirements. D: Total # of MCO case managers reviewed.

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

Data Aggregation and Analysis:

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

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

Performance Measure:
15C: Provider staff complete all training requirements for the specific CCP services provided and as required as a condition of the provider contract with the State.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
IDoA Training Certification for CCUs

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

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Provider Agency	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Online Training Tracking System

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

Data Aggregation and Analysis:

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

☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Annually, IDoA completes a Contract Review Checklist at each CCU that includes items to assure compliance with the agency's contract such as operational information (hours of operation, holidays), address/location, and policies/procedures adhered to. Upon signing the checklist, each agency is certifying that they are complying with all rules, regulations, and policies of IDoA.

After conducting compliance reviews, IDoA summarizes information on each performance indicator in management reports targeting the following users: HFS, IDoA, CCUs, providers and care coordinators. HFS and IDoA review the statewide management reports during quarterly meetings. These reports help the two agencies identify potentially problematic trends and to track the effects of remediation efforts to improve performance. Similarly, detailed reports for each level of entity are shared quarterly. These reports provide the basis for trend identification and specific areas of problems, leading to remediation. When individual problems with existing provider qualifications and contract compliance are identified, there is an initial effort to resolve the situation. In the case of problems identified through the complaint system, the State requires resolution within fourteen days. For other types of compliance problems, the State makes an initial request for corrective action. This corrective action request is tracked until there is a successful resolution. If there is not successful resolution, the State may take contract action under Rule 240.1665. These actions include 1) suspension of new referrals; 2) fines; or 3) contract cancellation.

HFS annually conducts comprehensive focused onsite reviews and statewide randomly selected record reviews. Service plan implementation and satisfaction is monitored during comprehensive onsite reviews.

HFS submits findings reports from routine monitoring to IDoA for follow-up and correction.

IDoA and HFS meet quarterly to discuss statewide management reports that include statewide data and corrective action that has been taken by IDoA. This provides an opportunity for HFS and IDoA to identify trends and issues, and to discuss remediation steps.

The Medicaid agency, HFS, will conduct routine programmatic and fiscal monitoring for both the OA and the MCOs.

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

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

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS' contracts with Integrated Care Program MCOs that provide waiver services. Contracts

specify numerators, denominators, sampling approaches, data sources, etc. Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants enrolled in an MCO through consumer surveys and quarterly record reviews. Participants in MCOs are included in the representative sampling.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
13C: New providers will be notified by the OA of lacking documentation. Receipt of respective provider licensure documentation or unable to enroll. Remediation within 30 days. Ongoing providers will be removed as a Medicaid provider in MMIS and the OA will request the respective provider documentation. Change of provider. Training for OA case managers. Remediation within 60 days.

14C: The CCUs will complete care coordination in accordance with contract requirements. If determined as part of contract review that any requirement(s) are not met, remediation must be completed within 60 days. If not remediated within 60 days, the MA has the option to implement sanctions.

15C: Completion of case manager training. Remediation within 60 days. Complete the training requirements. The OA/MCO submit a plan for how to assure training requirements are continually met. Remediation within 60 days.

16C: The EQRO monitors each MCO to ensure that initial case manager/care coordinator qualifications and training are met, as well as the completion of annual training. Oversight of case manager/care coordinator caseloads are reviewed during the post implementation review and during the administrative compliance reviews.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.
The State has all components of the proposed quality management strategy for this area except for the online system to track training. The online training-tracking system is anticipated to be implemented during Year 2 of the waiver. Until that time, providers must maintain records and IDoA will review paper records during the

annual desk audit.

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.

Program eligibility is based upon scoring of an assessment tool, the Determination of Need. A service cost maximum is the total amount of funding available for services and is derived from the assessment score. This funding covers services provided in a given month.

The installation of the Personal Emergency Response system is not included in the monthly Service Cost maximum, however, the monthly rates are included.

DON

The DON is the assessment tool used to determine an individual's non-financial eligibility for CCP services based on the individual's impairment in the completion of the Mini-Mental State Examination (MMSE), Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) and the individual's need for supports not met by unpaid caregivers or other resources. This assessment is made to determine whether or not the individual is at imminent risk of institutionalization without services, and therefore

eligible for placement in a nursing facility or services through the wavier.

Service Cost Maximum
The DON score corresponds to a specific service cost maximum that is the total amount of funding that may be expended on services for an eligible individual.

Participants actively participate in plan development and are informed of the various service options that are available. Participants agree to and must sign the plan of care before services are provided. Participants and their providers are always given copies of complete plans of care.

☐ **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.

1) For this waiver only non-residential settings must comport with the settings rules. The particular setting that must meet federal rules is those settings that provide adult day services. All other services under this waiver are provided to participants in their own home which is presumed to be an integrated setting.

Typically, in Illinois, adult day services' settings are in street locations in residential and commercial neighborhoods including small shopping plazas. There are a few settings that are located in physical environments that may not fully comport with the HCBS settings rules. In addition to the settings' physical locations, the State also examined the participants' level of autonomy and frequency of independent behaviors at the HCBS settings. Site visits will be made to some settings to determine the degree to which they comply with HCBS rules. The assessment process will lead to identification of areas needing revision, followed by a remediation phase and then, to compliance with the settings rules.

The Illinois Statewide Transition Plan to Comply with the Department of Health and Human Services Centers for Medicare and Medicaid (CMS) 2249-F and 2296-F Regarding Home and Community-Based Services (HCBS) Settings Rules in Illinois' 1915c Waivers submitted on March 16, 2015 describes in detail the complete processes to determine how these adult day services settings meet the federal requirements at the time of submission of this renewal and how the State will assure compliance in the future.

The State is not affirming that all adult day service settings comport with the Department of Health and Human Services Centers for Medicare and Medicaid (CMS) 2249-F and 2296-F Regarding Home and Community-Based Services (HCBS) Settings Rules at this time. It is only through the implementation of the Illinois Transition Plan which describes a process that began in 2014 and will conclude in 2019 that Illinois will be in a position to affirm that its settings comport with the Department of Health and Human Services Centers for Medicare and Medicaid (CMS) 2249-F and 2296-F Regarding Home and Community-Based Services (HCBS) Settings Rules.

In terms of further assuring compliance in the future, the process and strategies as stated above and in the Transition Plan determine the current status of the settings and provide a methodology to assure compliance. Once determinations and corrective or remedial plans have been implemented, if necessary and fulfilled, the Transition Plan defines how the State will ensure compliance in the future. Additional monitoring tools and sub-assurances will be added, if needed and utilized when

the MA and OA conduct their routine quality assurance activities. Illinois' strategies to monitor waiver compliance and adherence to assurances and sub-assurances are defined elsewhere in this renewal document.

2) The process in which Illinois will ascertain that all non-residential HCBS settings comport with the Rules is described the Illinois Statewide Transition Plan to Comply with the Department of Health and Human Services Centers for Medicare and Medicaid (CMS) 2249-F and 2296-F Regarding Home and Community-Based Services (HCBS) Settings Rules in the Illinois' 1915c Waivers submitted on March 16, 2015.

Specifically, Illinois established a LTSS Inter-Agency workgroup in April, 2014 which will continue to meet throughout the implementation of the Statewide Transition Plan. Initially, the workgroup's focus was on understanding the new regulations and the specific requirements for the development of the Statewide Transition Plan. Subsequently, its focus was on assessing the State's current compliance. The assessment phase referred to in the previous question, included the collaboration with an independent, outside entity, the University of Illinois at Springfield (UIS), Survey Research Office. The UIS team collaborated with the Inter-Agency workgroup to design, distribute and analyze a HCBS Waiver provider residential and non-residential setting surveys. Additionally, the assessment process included convening a smaller workgroup of representatives from the State's legal teams to review existing State statutes, administrative rules, and provider requirements to determine language that would need to be amended to comply with the new regulations.

The surveys produced essentially an inventory of our settings and provided to the State a picture of our current status in relationship to the Rules. The survey results ultimately categorized the settings into the four federally defined categories of:
1. Fully align with the federal requirements.
2. Do not comply with the federal requirements and will require modification.
3. Cannot meet the federal requirements and require removal from the program and/or relocation of participants.
4. Presumably non-home and community-based, but for which the State will provide justification/evidence to show that those settings do not have the characteristics of an institution and do have the qualities of home and community-based settings (heightened scrutiny).

Based upon an initial determination, approximately 6 adult day settings fell into categories 2, 3 and 4. All of these settings will have a site visit. During the site setting validation visit, the process will include:
1. A participant survey to be distributed to site/setting participants and/or their representatives;
2. A focus group or series of focus groups depending on the size of the site/setting with participants and/or their representatives;
3. Meetings with key staff at the site/setting which include reviews of the self-administered survey, internal policies and procedures and documentation of community integration; and
4. Sample file reviews looking at individual participants' Plans of Care.

Through these described methods, the State may obtain additional information in order to make a recommendation regarding the site settings' compliance. This recommendation will state whether or not this individual site setting in-fact is an integrated setting. If a recommendation is made for heightened scrutiny, it will be provided to CMS for their determination.

The State's remediation strategy intends to encompass both system-wide compliance and provider-specific compliance. Based on further analysis of the survey responses, information gained during site visits, and comments from the public, advocacy groups, participants and families, the State anticipates making revisions to policies and procedures in the areas of autonomy, community engagement, transportation, employment opportunities, and settings' amenities and accommodations.

Furthermore, based upon follow-up site setting validation visits to adult day care providers, the OA under whose jurisdiction these settings operate along with MA, will notify these providers who are not in compliance with the new regulations. In the MA and OA report, specific explanations are to be presented to the providers regarding areas of their service setting and practice which do not comply with the new regulations. The MA and OA will ask the providers to develop an action plan to bring them into compliance.

The process for coming into compliance may include the following steps:
• Providers may implement requested changes and/or provide additional information;
• The State may provide guidance regarding areas needing additional remediation and establish timeframes for remedial actions to be completed;
• Provider groups under the direction of the State may work together to assist each other in bringing their programs into compliance;
• Providers may submit scheduled progress reports to the State on the changes they are making;
• Successful actions completed by providers to bring their settings into compliance may be posted on the HFS website, in order to inform the public as well as assist other providers;

• The State may complete an on-site visit to assure that required changes have been made.

Ultimately at the end of the assessment, discovery and remediation processes, the State will ascertain that all Adult Day Service settings which are contracted Medicaid providers have a location and policies and practices that comport with the HCBS Settings rules. For those that do not, steps will be taken to assure the health, welfare and safety of participants as they transition to other settings and/or services.

Once a site has been validated, additional monitoring tools and sub-assurances will be added and utilized when the MA through its QIO contracts and when the OA conduct its routine quality assurance activities to ensure ongoing compliance. Illinois' strategies to monitor waiver assurances are defined elsewhere in this renewal.

As the State proceeds with the implementation of the Transition Plan, the State will keep all managed care entities informed of what we learn and the outcomes of the site settings validation visits. The State will subsequently require all of its managed care entities to review all its contracts with adult day service settings to ensure their contract language and practices of the settings comport with the HCBS rules. The QIO under contract with the MA will similarly monitor adherence by using additional monitoring tools and sub-assurances as described above relating to the HCBS settings rules and for on-going compliance.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Plan of Care (POC)

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)
- [x] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Minimum qualifications for care coordinators:

1) Be an R.N, or have a B.S.N, or have a B.A./B.S. 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 LPN with one year of program experience which is defined as assessment of a provision of formal services for the elderly and /or authorizing service provision; or
3) Be waived for persons hired/serving in this capacity prior to December 31, 1991. Provision of a waiver for care coordinators hired prior to December 31, 1991 was based on their years of experience. These care coordinators must maintain certification for a case manager and must also follow in-service requirements.

Care coordinators must also complete the following Department sponsored training:

1) Preliminary Community Care Program (CCP) training that must occur prior to conducting participant assessments;
2) CCP Certification training and successfully pass the required exam within six months of completing Preliminary training; and
3) Recertification training within each 18-month anniversary of each previous certification.

Care coordinators must also complete 18 hours of documented in-service training on aging related subjects within each calendar year. For partial years of employment, training shall be prorated to equal 1.5 hours for each full month of employment. Documented participation in in-house staff training and/or local, state, regional, or national conferences on aging related topics in addition to the Department sponsored Preliminary, Certification and Recertification training will qualify as in-service training on an hour-for-hour basis.

For participants enrolled in an MCO, the care coordinators are responsible for service plan development. Qualifications for the care coordinators vary within each of the Plans, and are assigned based on individual need and identified risk. At minimum, qualifications include the following license or education level:

Registered Nurse (RN),
Licensed Clinical Social Worker (LCSW);
Licensed Marriage and Family Therapist (LMFT);
Licensed Clinical Professional Counselor (LCPC)
Licensed Professional Counselor (LPC);
PhD;
Doctorate in Psychology (PsyD);
Bachelor or Masters prepared in human services related field;
Licensed Practical Nurse (LPN)

The MCO care coordinators are required to complete 20 hours of training, initially and annually, as specified in the MMAI contract. They are not required to complete the Department sponsored training; however, if they do complete the Department sponsored training, it will be counted toward their total hours of required training.

MCO care coordinators must be trained on topics specific to the type of HCBS Waiver Enrollee they are serving. For the Elderly Waiver, training must include Aging related subjects.

☐ **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:*

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) Supports and information available to participant/customer

OA Process:

Participant -Centered Planning begins with a participant/customer centered assessment and re-assessment conducted by a Care Coordinator from the local Care Coordination Unit, which is an independent Care Coordinator and not linked to any provider of service. Forms and documents articulate specific expectations of participant centered planning to direct and be actively engaged in the service plan development process; however the service plan development process is considered a practice issue. So, while the State employs several means to support and inform the waiver participant/customer and his/her circle of support of the participant/customer's rights, it requires a skill set and expertise of care coordinators to engage waiver participant/customer and treat them as the driver of the Participant Centered Plan of Care. The development of this skill set and the approach to participant/customer inclusion at all levels of assessment and participant centered plan of care development requires on-going training and is a critical component in the hiring and supervision of persons performing care coordination.

Routine practice of the Care Coordinator includes asking the waiver participant/customer who, if any individuals the participant/customer would like to attend the care planning session. As the date and time is set for the care planning assessment and discussion, the care coordinator is to make every accommodation possible to satisfy and include all persons identified by the participant/customer. It is expected that in all conversations between the care coordinator and the participant/customer be participant/customer focused, constantly reinforcing that planning is a collaborative effort, enabling the waiver participant/customer to lead the process to the best of his/her abilities and that the outcome of the process is a Participant Centered Plan of Care in which the plan is one that is owned and agreed to by the participant/customer.

Written materials pertaining to the waiver are being updated to ensure language in all materials informing the waiver participant/customer of his/her rights comport with HCBS rules. These documents include statements in the Home Care Consumer Bill of Rights and Things You Need to Know informing the participant of their right to appeal. These documents includes statements pertaining to the participant's right to include those he/she wishes to participate in all assessments and the development of a plan of care reflective of the individual's needs, preferences, goals and health status.

In addition, the language in these documents articulate the ability of the participant/customer to include all persons chosen by the participant/customer to be included at all informational gathering, assessment and reassessment meetings. Language states that times of these meetings should occur at times and locations convenient with the understanding that to fully assess participant/customers needs, it is to be completed in their home environment and that the waiver participant/customer is in essence the driver of the participant/customer centered plan development. Language states that the conversation between the waiver participant/customer and the care coordinator is to be goal centered.
In order to achieve a holistic person-centered approach the OA has set the expectation that care coordination encompasses a comprehensive assessment of the participant's situation and circumstances related to all factors contributing to health, welfare, safety, community integration, quality of life, ability to live independently in the community and the participant's vision for his/her quality of life. The CCP utilizes the Comprehensive Care Coordination (CCC) assessment tool for this holistic approach. The CCC is a process that utilizes a tool that includes a review of the participant's environment in the community, physical, cognitive, psychological/emotional, and social well-being. It also includes identification of existing support systems and the need for further evaluation(s) by other disciplines. The CCC tool covers eleven domains; participant demographics, physical health history, behavioral health, Determination of Need (DON) & Mini-Mental Status Exam (MMSE) evaluation, medications, nutrition, caregiver, transportation, environmental, financial and legal. Information collected in the CCC assessment is used to help the care coordinator and the participant form the POC. Risk factors, such as depression, alcohol and substance abuse, medications, caregivers, health, falls and behaviors, are identified and addressed throughout the domains of the CCC assessment tool. Care coordinators are trained to discuss potential risks with the client and work together to develop a POC that will minimize or eliminate the risk.

The CCC prompts the Care Coordinators to ensure all areas of a holistic assessment is captured and what the participant hopes to achieve from the delivery of waiver services, as well as other available options is included. The Person Centered Plan of Care that emerges from this assessment and conversation is one that encompasses all participant needs, desires, goals and vision and links the participant with an array of options, not just those programs and services that are components of the waiver.

The Plan of Care that is the result of this comprehensive assessment identifies what does the waiver participant hope to realize as life goals and desires and what supports; both waiver services and non-waiver services can assist the participant/customer in actualizing these goals and desires. The written documentation in the development of the Plan

of Care and other assessment forms utilized during the assessment/reassessment processes indicate that the waiver participant exercised choice in the decision making process.

As mentioned above, the Home Care Consumer Bill of Rights which was enacted August 15, 2014 into State law outlines the State's commitment to assuring the rights of all home care consumers emphasizes participation in planning, self-determination, choice, dignity and individuality. This Consumer Bill of Rights is to be provided to and discussed with the participant/customer at all assessments and sessions where planning occurs.
Assessments and Reassessments are based upon changes in participant circumstances such as following a recent hospital visit, loss of a caregiver and/or changes in the person's health status. The process described above at all types of assessments and follow-up conversations regarding care plan implementation.

MCO Process:

The same processes of how an assessment and/or reassessment described above by the OA is expected of care coordination provided by Managed Care. MCO care coordinators are expected to engage the participant/customer and assure that he/she directs the process as much as possible by asking and encouraging at all levels of the assessment, reassessment and care planning interview processes. All accommodations are to be given to anyone he/she wishes to include in the discussions and meetings to develop a holistic person centered plan of care.

As stated as critical element of the process, is the professional practice of the MCO Care Coordinator. The engagement and inclusion of the participant/customer and those that he/she designates to be included in the process requires training and expertise by the Care Coordinator. The MCO assessment tools and those given to them by the OA, prompts the care coordinators to ensure all areas of a holistic assessment is captured and that it reflects the goals, desires and needs of the participant/customer. The resulting Participant Plan of Care is to reflect what the Participant/customer hopes to achieve and meet the participant/customer expectations, to the best of ability of available programs and services that include waiver and non-waiver programs and services. The Person Centered Plan of Care that emerges from this assessment and conversation is one that encompasses all participant/customer needs, desires, goals and vision and links the participant/customer with the whole array of options, not just those programs and services that are components of the waiver.

The MCO entities have assessment tools that contain components that are used to elicit and achieve holistic and comprehensive information from the participant/customers to support a person centered service plan of care. Components in the assessments include, but are not limited to cognitive/emotional ADLS, IADLS, behavioral health, medication, living supports, environmental conditions, and health care information. The Plans review the State's assessment/Level of Care instruments, conducted by the OA. In addition, the MCO care coordinator's assessment secures information that include the member's strengths, needs, personal goals and desires, levels of functioning and risk. The participant/customer's person centered plan of care is to be reviewed within 90 days of initial implementation of the service and reassessed as needed. A re-assessment is to occur, at a minimum annually. All care coordinators are trained to discuss potential risks with the client and work together to develop a POC that will minimize or eliminate risk. Through the assessment and care planning process, the participant/customer's goals and the strengths and barriers to achieving these goals are identified.

MCO Care Coordinators are also required to enable as much choice as possible with the MCOs offering options of providers in order to accommodate participant/customer preferences and choice. By terms of their contract with the MA, the Plan must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area to assure that the Affiliated Providers served at least eighty percent (80%) of the number of Participant/customers in each county who were receiving such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) of such Providers, so long as such Providers accept Contractor's rates, even if one (1) served more than eighty percent (80%) of the Participant/customers, unless the Department grants Contractor an exception.

(b) The participant/customer's authority to determine who is included in the process. (OA and MCO Processes)

The participant/customer's right to determine who is in included in the process is articulated in the Home Care Consumer Bill of Rights. This is to be given to all participant/customers at the time of assessments and reassessments. Also, as described in (a) above for both the OA Care Coordinators and those of the MCOs, Care Coordinator's practice requires that they routinely inquire and document the participant/customer's authority to determine who is included in the process. This is documented in the Participant Plan of Care.

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 State is committed to participant centered care plans. The care coordinators are trained to include the participant in every aspect of the assessment and service plan development.

For the OA, the CCU contacts the participant or authorized representative, usually by phone, prior to the scheduling of the assessment. Assessments are generally conducted in the participant's residence except for redeterminations of Adult Day Service (ADS) participants, which may be conducted at the ADS site. The care coordinator schedules the visit around the participant and other parties that the participant wishes to have included.

a) Development of plan, participation in process, and timing of the plan:

OA Process:

The care coordinators conduct a face-to-face comprehensive assessment of the participant. The assessment contains a "goals of care" section where participants express their goals, which include those related to service needs, overall life goals or desires and their expectations for care. Goals are holistic and are not restricted to only needs that will be addressed by waiver services. If the waiver participant voices a desire to attend a house of worship or go to the lectures at the library, these should appear under goals and be articulated in the Participant Centered Plan of Care. Participants and anyone they wish to include are to have an active role in the development of the Person Centered Plan of Care. This includes choosing services and service providers. The face-to-face assessment is conducted in the participant’s residence as this is most convenient and enables the care coordinator to see the participant function in their home environment. Reassessments, if necessary may on occasion take place at the provider setting if it is determined that an assessment in the home is not an option.

In terms of timing, initial assessments, including eligibility determination, must be completed with participants within 30 calendar days of request for services unless client delay occurs. Reassessments must occur within 30 calendar days of participant request. Waiver service providers have a maximum of 15 calendar days to begin providing services to the participant from the date of the written notice of eligibility to the participant. These timeframes are maximums, and in most cases the process is completed much sooner. For those participants that are in imminent risk of being placed in a nursing home, care coordinators can request that participant’s receive interim services which require service providers to start services within 2 business days from the date of participant notice.

MCO Process:

The service plan is developed by the Plans’ care coordinators in collaboration with the waiver participant and/or their representative in following the same expectations as those set by the OA for the CCUs. Similarly, the MA has set the same expectations regarding the location of assessments and reassessments as stated above. Also, the timing of initial assessments and reassessments are the same.

b) Types of assessments conducted to support the service plan development process, including securing information about participant's needs, preferences and goals, and health status:
OA Process:

In (a) above, the process in all assessments is to have the participant articulate his/her needs, goals, and desires. Using this as a basis for a holistic approach to care coordination, the assessment of the participant’s situation and circumstances identifies all factors contributing to quality of life and the participant’s ability to live independently in the community. The CCP utilizes the Comprehensive Care Coordination (CCC) assessment tool for this holistic approach. The CCC tool includes a review of the participant's environment in the community, physical, cognitive, psychological, and social well-being. It also includes identification of existing support systems and the need for further evaluation(s) by other disciplines. The CCC tool covers eleven domains; participant demographics, physical

health history, behavioral health, Determination of Need (DON) & Mini-Mental Status Exam (MMSE) evaluation, medications, nutrition, caregiver, transportation, environmental, financial and legal. Information collected in the CCC assessment is used to help the care coordinator and the participant form the POC. Risk factors, such as depression, alcohol and substance abuse, medications, caregivers, health, falls and behaviors, are identified and addressed throughout the domains of the CCC assessment tool. Care coordinators are trained to encourage the participant to direct the assessment as much as possible and to discuss potential risks and work together to develop a POC that will minimize or mitigate/eliminate the risk.

MCO Process:

The Plans have similar comprehensive assessment tools to the CCC that contain components that are used to elicit a wide-range of information from the participants and their representatives to support service plan development. These components in the assessments include, but are not limited to cognitive/emotional, ADLS, IADLS, behavioral health, medication, living supports, environmental conditions, and health care information. The Plans also review the Determination of Need, which identifies ADLs and IADS and need for care which is conducted by the OA. The assessment secures information including the member's strengths, needs, levels of functioning and risk factors. Through the assessment and care planning process the participant's goals and the strengths and barriers to achieving these goals are identified. Again, the MCOs similar to the CCUs are trained to look at the individual and approach the participant to direct the process.

The MCO contract specifies expectations for waiver clients, including content of and purposes for Enrollee Care Plans and HCBS Waiver service plans (for enrollees receiving HCBS Waiver services). As part of its work on behalf of HFS, the EQRO reviews assessments as part of its pre-implementation record review, onsite post-implementation record review as well as in quarterly record reviews to make sure the assessments meet contractual requirements.

c) Informing customer of services available under the waiver:

OA Process:

After the care coordinator determines eligibility and completes the CCC assessment, they discuss with the participant the array of services, regardless of funding sources, which are available to them and to what they are eligible. The array of services also includes the participant's goals that may not be met by a waiver or other formal service. It is the care coordinator's responsibility to explain all service options to the participant, including, but not limited to waiver services. Care coordinators are required to go through Case Management training that includes training on comprehensive care coordination. This training outlines services that are available through other state and federal agencies, local entities, and charitable organizations. IDOA utilizes local Area Agency on Aging (AAA) staff as co-trainers during these trainings to discuss available Older Adult Services (OAS) services and local resources in each area. The participants are required to sign the CCC assessment to ensure that it adequately represents their goals for care and that the care plan is designed as they want. Participants also sign a program consent form verifying that service options were explained to them and that they had freedom of choice in choosing their service and their service providers.

MCO Process:

The participant is informed by the Plan of the covered waiver services:
At the initial face-to-face visit by the case manager; in conjunction with the review of the member handbook/inserts
Annually when the Plan's case manager reviews the member handbook/inserts with the participant
In addition, the care coordinators are to encourage the participant to take the lead in plan development and to identify services that might not be included in the Plan, but reflect additional goals and desires of the participant. The Participant Centered Plan that emerges from this conversation is to reflect both Plan covered including waiver services and informal services.

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

OA Process:

The CCC assessment identifies unmet needs in 11 domains. The tool includes a summary section at the end of each domain that summarizes the needs identified by the care coordinator and participant during the assessment. These summary sections are then identified on the participant's goals of care and service plan. The Determination of Need (DON) assessment identifies level of need and unmet need for care. The DON assesses 15 areas including; eating, bathing, grooming, dressing, transferring, continence, managing money, telephoning, preparing meals, laundry,

housework, outside the home, routine health, special health and being alone. Any unmet needs on the DON have to be addressed on the POC. Participant's preferences are obtained throughout the entire assessment process including during the development of the individualized and participant-centered service plans. Participants must sign the CCP consent form indicating that they were given a choice of services and a choice of provider agencies.

MCO Process:

Comprehensive assessments are developed 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 (for enrollees receiving HCBS Waiver services).

After the comprehensive assessment has been completed by the MCO, 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 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 Participant Centered Plan of Care. As this is participant-centric, personal preferences are integral to the development of the service plan, such as cultural preferences and provider preferences for language and gender. The service 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 participant.
As part of its work on behalf of HFS, the EQRO reviews assessments as part of its pre-implementation record review, onsite post-implementation record review as well as in quarterly record reviews to make sure the assessments meet contractual requirements.

e) Explanation of how waiver and other services are coordinated:

OA Process:

The CCC is completed at the initial assessment and at least annually thereafter. This tool ensures that no duplication of services exists. The POC includes all other services the participant is receiving, regardless of funding source. The POC is then sent to each waiver provider on the POC so that the providers are aware of additional services or assistance in the home. Providers are trained to report any changes in the participant situation to the CCU including a disruption of other, non-waiver services. Identifying all agencies in the home on the POC assists the provider agencies to know who should be in the home and during what times, providing an additional level of quality assurance.

MCO Process:

Services are coordinated by the participant's assigned Plan case manager, who is responsible for the identification, authorization, and assignment to the responsible service provider in coordination with and direction from the participant and/or their representative.

f) Explanation of how the plan development process provides for the assignment of responsibilities to implement and monitor the plan:

OA Process:

IDOA mandates that upon initial assessment and every assessment thereafter, the care coordinator must provide the rights and responsibilities brochure to the participant. In addition, a Participant's Bill of Rights is to be added in WY 1 reflecting language that comports with Participant Centered Planning and rules related to settings. These brochures outline the responsibility of the participant and in regards to the Bill of Rights, those responsibilities of the MA and OA as it relates to receiving services. Included in these responsibilities of the participant is the responsibility to notify the care coordinator/CCU of any changes in their status, i.e., hospitalizations, changes in needs, changes in financial status, etc. The Department mandates that this brochure not only be given, but also explained and reviewed with the participant. Documentation in the participant's case record must support that this mandate was met. Provider agencies are also mandated to notify the care coordinator/CCU of changes in the participant's status. Department policies and training outline the responsibilities of the care coordinator. These responsibilities include development of the Participant-centered POC and continually monitoring of the service plans.

MCO Process:

The Plan case manager is responsible for the execution of the service plan, which includes monitoring the provision of waiver services and risk mitigation strategies. The participant's role is clearly defined in the care plan, and the participant is responsible for actively participating and providing feedback. The Participant's Bill of Rights, as

described above, will be added to the documents provided to participants receiving waiver services in WY 1.

g) Explanation of how and when the plan is updated, including when the participant's needs change:

OA Process:

Department administrative rules require that participants receive a new assessment at least annually if there is significant change and upon participant request, within 30 calendar days of participant request or within 15 days following discharge from a hospital or other institution. Participant's Plan of Care are reviewed and adjusted during each assessment. Participants can request a change to the POC at any time.

MCO Process:

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning. The participant's service plan development begins with a comprehensive in-person assessment of the participant's health and supports, services needs, and their preferences and goals. Based on the outcome of the assessment, the care coordinator works with the participant to develop a service plan reflective of his/her goals, needs and choices. The participant's family and circle of support, if the participant so chooses, or his/her legal representative may be involved in every step of the assessment and planning process.

After each comprehensive assessment is completed, in which the member's current status and needs are identified; a new participant centered service plan is completed. During the assessment, and as needed in-between assessments, the Plan's case manager educates the participant to call the case manager to request a change in the plan if the participant's situation or needs change in-between assessments. The participant 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 services. Service plans can be created or adjusted in-between assessments to meet the member's immediate needs. Whenever there is a significant change in level of service needs or functioning (for example, hospitalization significantly impacting the participant's level of functioning), a new assessment is to be completed and additional services provided as needed.

The participant is in the center of the care/service planning process. The Plan case management staff completes a comprehensive assessment to identify the participant's strengths, needs, formal and informal supports based on information provided by the participant or representative. The participants have an active role in choosing the types of services and service providers to meet those needs. The case manager obtains the waiver participant's signature of agreement on the service plan and offers the waiver participant a choice of providers to fulfill the services
The Plan's case manager is responsible for providing clear direction to the participant regarding appeal rights whenever a reduction, termination, or suspension in service(s) occurs. The appeal rights are summarized in the service plan that the participant signs at the initial assessment, and each reassessment thereafter. If the member appeals, the services 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 participant also provide information on appeal rights and processes.

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.

As our care coordinators assess for participant needs, they are evaluating current participant risks and work with the participant to identify the resources and strategies to mitigate these risks through the linkage and delivery of services ultimately to prevent institutionalization and be successful in community residency. For example, if the participant is at nutritional risk, through the use of a home care worker or Older Americans Act funded home delivered meals may be part of the Participant Centered Plan of Care to mitigate this risk.

A significant strength in this waiver's approach to assessment is the CCC assessment tool which requires the care coordinator and participant to discuss a whole range of domains beyond those that waiver services may mitigate risk, but also may be issues that impact the success of the waiver service or any formal or informal support to mitigate the risk.
Risk factors that could encompass such domains included in the CCC assessment tool, such as behavioral health of

the participant including depression, anxiety and abuse of alcohol or other substances including illegal substances and medications; role of caregivers; physical health; occurrences and risks of falls are explored and addressed.

The CCC assessment develops with the inclusion of participant a comprehensive care plan. It also includes a back-up plan to the Participant Centered Plan of Care. The back-up arrangement is specific to the participant's needs and preferences. Care coordinators are trained that a back-up plan is not 911, but one that utilizes other formal social service agencies as well as family, neighbors and friends, and assistive technology devices. Together the Care Coordinator, participant and anyone else the participant elects to be engaged in the process discuss possibilities of both formal and informal options in the event that the services arranged for in the plan of care are not provided and establishes a back-up plan of care. The participant is asked to post their back-up in a convenient place, such as his/her refrigerator in order that if the need arises for using the back-up plan it is available and in sight.

Additionally, per CCP rule [240.1510 q], provider agencies are responsible to have a policy for an all hazards disaster operations plan including but not limited to medical emergencies, home or site-related emergencies, participant-related emergencies, weather-related emergencies and vehicle/transportation emergencies. For example, in-home service agencies train their home care aides to make additional meals for storage and reheating during times of inclement weather just in case a home care aide cannot access a participant due to inclement weather.

MCO Process:

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning. The assessment for potential risk is included in the service plan development process. The care coordinator at the MCO is expected to incorporate and utilize the same strategies as describe above in the development of the Participant Centered Plan of Care. Again, strategies to reduce, mitigate and eliminate risks must be identified. In addition, the care coordinator develops the backup plan and works with the participant to ensure necessary arrangements for back-up in-place.

The Plan’s case manager completes a comprehensive assessment and care planning process for every participant. This process includes identification of the participant’s cognitive/emotional functioning, behavioral health, medication, living supports, environmental conditions, ADLS, IADLS and health information. This process identifies risks that could encompass such domains as the behavioral health of the participant including depression, anxiety and the abuse of alcohol or other substances including illegal substances and medications; role of caregivers; physical health; occurrences and risks of falls. These are explored and addressed as they may increase and serve as barriers to the members’ ability to live as safely and independently as possible. All risks are identified and discussed in the service planning process. Through service planning interventions, identified risk(s) are mitigated and barriers are addressed with interventions which are mutually agreed upon by the participant and the Plan.

Additionally, a backup plan is formulated for every participant who lives independently in the community and receives waiver services. The backup plan addresses the services currently in place, the urgency for receiving backup services should the current service be interrupted, and specific written instructions for addressing the gap. This includes names and telephone numbers of persons or agencies who are available to immediately assist in a backup arrangement. The list may consist of family, friends, community supports, or provider agencies.

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.

OA Process:

Care coordinators are notified of all certified contractual providers that provide services in their areas. The State requires that freedom of choice be afforded to every participant in the CCP. The care coordinators meet with the participants to discuss the goals of care, desires and develop the Participant Centered Plan of Care. It is the care coordinator's role to provide information about the available service providers to each participant and to answer any questions that arise. If the participant has no preference of a provider agency then the care coordinators are required to utilize a rotating service provider list. This list includes all service providers and is maintained at each local CCU office. Participants must sign a consent form that indicates that they were afforded freedom of choice or that they requested a provider agency be assigned to them from the rotation list. Information of available providers is available on the IDoA's website also for participants and their families to review. IDoA is committed to increasing the amount

of information that is available via the Internet on service providers. Each service provider is also encouraged to have its own brochures and advertising material available upon participant or care coordinator request. Participants and families are encouraged to visit ADS providers before admission. Participants/authorized representatives identify the provider chosen and sign the Consent Form and Client Agreement to verify that the providers selected.

MCO Process:

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning. The care coordinator assists the participant in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

It is the Plan's care coordinator's role to provide information about the available services and service providers to each participant, and to answer any questions that arise. The Plan will assist the participant through the provider network supplying provider information relevant to the services selected by the member on their service plan and available in the member's service area. Participants always have first choice on the providers they select to meet their needs. Plan care coordination staff supports 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 are made available to participants upon request. The participant is also educated that the Plan's provider list is available on the Plan's website.

MCO Plans must have contracts in-place with a sufficient number of such Providers within each county in the Contracting Area to assure that the Affiliated Providers served at least eighty percent (80%) of the number of Participants in each county who were receiving such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) of such Providers, so long as such Providers accept Contractor's rates, even if one (1) served more than eighty percent (80%) of the Participants, unless the Department grants Contractor an exception. It is the State's goal that this will insure choice on behalf the member participant.

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):

Service plans are subject to the approval of the MA. The OA and the MCOs have day-to-day responsibility for completion and approval of service plans; however, the MA, through its Quality Improvement System, reviews service plans through a sample process as described below.

For the OA, HFS reviews a sample of service plans when monitoring IDoA, the OA. During these reviews, plans of care are reviewed for compliance with state and federal regulations. Reports of findings are shared with IDoA and recommendations for improvement are made. The OA responds to the HFS reports both on an individual and systemic basis. Information is shared during quarterly meetings between HFS and IDoA.

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

Once the MA selects the sample, it is provided to the MA's External Quality Review Organization (EQRO), the entity responsible for monitoring the MCOs. The OA and the EQRO determine a review schedule, based on the sample and performs onsite record reviews to assess compliance with the service plan performance measures. For the MCOs, the EQRO sends a report of findings to the MA and the MCOs. The MCOs are required to remediate findings within required timelines, and report remediation activities to the MA, at least quarterly. The MCOs report on both individual and systemic remediation.
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Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

- ☐ **Medicaid agency**
- ☑ **Operating agency**
- ☑ **Case manager**
- ☑ **Other**

Specify:

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 CCU/care coordinator is responsible for monitoring the implementation of the service plan and the participant's health, safety and welfare.

a) Care coordinators and participants develop the POC together during the initial assessment and at each reassessment the POC is reviewed and adjusted as needed. Department administrative rules require that participants receive a new assessment at least annually, when there is significant change, within 30 days of participant request and within 15 days of discharge from a hospital or institution.

The CCC assessment addresses all aspects of participant function and supports. The care coordinator identifies services needed and makes the appropriate referrals, as agreed upon by the participant and the care coordinator during the CCC care plan process. Referrals are made to a variety of services including those outside the services offered in the elderly waiver. Care Coordinators are trained to utilize local and regional funded services in addition to waiver services whenever appropriate. Examples of additional services include home delivered meals, medication management, flexible senior services, respite care, transportation, and medical and home health services.

b) The CCUs/care coordinators monitor the provision of services through participant contact, intensive case monitoring as applicable, and satisfaction surveys.

The participant, authorized representative, provider agency or care coordinator can request a follow-up by the care coordinator. When problems are detected, service plans can then be revised or new a service plan can be implemented. For those clients with complex care plans requiring more intensive follow-up to ensure that the additional referrals are in place and working properly, the program allows care coordinators to provide Intensive Case Work and Intensive Monitoring.

The CCC assessment triggers the need for more intensive case monitoring. For example, a participant that requires a complex care plan utilizing service providers both within the waiver and outside the waiver would be appropriate for

Intensive Case Work. This allows the care coordinator to devote more time to making the appropriate referrals within the community and making sure that the participant has a complete care plan that will meet their needs. Intensive Monitoring is authorized for up to three months to allow the Care Coordinator time to ensure that the care plan is working and is meeting the participant's needs.

c) Care coordinators are required to meet face to face with waiver participants at least annually, and more often as needed. Intensive monitoring is available for participants that require more frequent management.

It is the participant's responsibility to notify the CCU of any change in status or to request a change to the POC. Participants can request a change to the POC at any time. Provider agencies are mandated to notify the care coordinator or CCU of changes in the participant's status. Department policies and training outline the responsibilities of the care coordinator, for development of the POC and continually monitoring of the service plans. Care coordinators can also authorize the Intensive Case work or Intensive monitoring for participants that require more frequent management. Intensive Monitoring requires a face-to-face meeting at least once in each month that it is billed.

For participants enrolled in an MCO, the Plan care coordinator is responsible for monitoring service plan implementation, including whether services and supports meet the participants' needs and back up plans are adequate.

For the Plans, the primary avenue to monitoring the participant's needs and service planning is the completion of the comprehensive assessments with the participant. The Plan case manager and the participant work collaboratively during the initial assessment and at each subsequent reassessment on the service plan process. The Plan case manager is responsible for monitoring the implementation of the service plan, the availability and effectiveness of identified services and supports, and the participant's overall health and welfare.

The case manager works with the participant to identify the agreed upon services to include in the service plan 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 plan of care. In addition to being completed at the initial assessment and reassessment visits, the service plan 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 service plan to ensure that services are furnished in accordance with the service plan and that the services provided by the service provider are meeting the needs of the participant. A new service plan will be created at each reassessment to capture members review and agreement with the service plan 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 case manager also reviews the backup plan to ensure it is still in effect and if the backup plan was utilized, it is discussed with the participant to ensure its effectiveness. The service plan, service providers, backup plan or referrals to non-waiver services may be made or modified to ensure the member's needs are adequately met based on these discussions.

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, service listed on the service plan address members need identified in the assessment, back-up plans are created for members receiving in-home services 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 MA 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 Plans will be required to report event and other data to the MA where sampling methodology is 100%. MA oversight will include onsite or desk audit validation in these areas.

The MA selects a statistically valid sample for conducting onsite record reviews to assure compliance with federal assurances. The MA uses a proportionate sampling methodology with a 95% confidence level and a 5% margin of error for both the OA and the MCOs. 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 State's quality improvement strategy, provide information in the following fields to detail the State's 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:
21D:# and % of MCO participants' service plans that address risks identified in the assessment. N: # of MCO service plans reviewed that address risks indentified in the assessment. D: Total # of MCO service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; EQRO Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: EQRO/MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
20D:# and % of MCO participants' service plans that address all personal goals identified by the assessment. N: # of MCO service plans reviewed that address all personal goals identified by the assessment. D: Total # of MCO service plans reviewed.

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

MCO Reports; EQRO Reviews

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

Data Aggregation and Analysis:

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

Performance Measure:
18D: Participants indicate a positive response (average of 4 on the scale) when

asked about opportunities for activities and community integration

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; POSM Survey

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

☑ **Other** Specify: MCO	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
17D: Each participant will have a written plan in place that identifies all needs, as indicated by a completed DON.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Event Reports; EQRO Reviews

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
19D: Participants indicate a positive response (average of 4 on scale) when asked about personal relationships.

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; POSM Survey

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: MCO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

Performance Measure:
22D: Upon contract initiation, at time of compliance reviews and at contract renewal, CCUs submit the CCU policies and procedures for developing plans of care to IDOA for review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Annual Contract Review Checklist

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

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

Data Aggregation and Analysis:

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

Performance Measure:
23D: # and % of MCO participants' service plans that were signed and dated by the waiver participant and the case manager within required timeframes. N: # of MCO service plans that were signed by the waiver participant and the case manager. D: Total # of MCO service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; EQRO Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**

☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: EQRO/MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
24D:# and % of MCO participants who received annual contact by their case manager in an effort to monitor service provision and to address potential gaps in service delivery. N: # of MCO participants reviewed who received annual contact by their case manager. D: Total # of MCO participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; EQRO Reviews

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

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: EQRO/MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's 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:
25D: All service plans are updated by the annual review date or when there is a change of status as indicated by a new DON.

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

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

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; EQRO Reviews

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
27D: The ratio of utilized services to the amount of services authorized is not lower than 80% percent.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Provider Agency (claims submittal)	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
26D: Services are initiated within 15 days of a determination of eligibility, unless delayed by the applicant and/or their authorized representative.

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; EQRO Reviews

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: MCO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
30D: Participants indicate a positive response (average score of at least 4) when asked about availability of paid care and supports

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

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

Data Source (Select one):
Other

If 'Other' is selected, specify:
MCO Reports; POSM Survey

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

Data Aggregation and Analysis:

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

Performance Measure:

28D: CCUs have documentation of monthly contacts for 100% of cases in which there is intensive monitoring as defined by rules.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case note tracking system

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

Data Aggregation and Analysis:

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

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

Performance Measure:
31D:# and % MCO participants who received services in the type, scope, amount, duration, and frequency as specified in the service plan. N: # of MCO participants reviewed who received services as specified in the service plan. D: Total # of MCO participants reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; EQRO Reviews

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

Data Aggregation and Analysis:

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

☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: MCO	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
29D: Participants indicate a positive response (average score of at least 4) regarding their relationship with workers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; POSM Survey

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

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

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

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and 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:
32D: 100% of waiver participants have a completed and signed freedom of choice section of the CCP Consent form specifying that choice was offered between institutional care and waiver service and choice of waiver providers.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; EQRO Reviews

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/-5%
☑ **Other** Specify: EQRO/MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

IDoA and its CCUs monitor, identify problems, and take corrective action related to the service plans. IDoA is responsible to oversee and report to HFS about findings associated with performance in this area, which occurs during each quarterly IDoA and HFS meeting.

Waiver services are delivered in accordance to services authorized by CCU on the service plan, including amount, scope, duration and frequency. There are times when the full monthly service plan cannot be fulfilled, which can occur for a number of reasons. For example, during the month the participant may have been out of state with family, hospitalized or may have declined services. The OA monitors the utilization amount of participant services on a quarterly basis, looking for trends to see if utilization decreases are explainable and at the request of the participant and to determine whether policy changes are needed to address systematic issues. During QI reviews, the OA also reviews the utilization of services. The provider agency must supply documentation of deviations when the service plan is not followed. Providers which do not have adequate documentation are given a corrective action to implement changes.

Care coordinators enter case notes directly into the case note tracking system. If a case note does not exist for the date of the casework or monitoring, IDoA will not reimburse the provider for that service.

eCCPIS is an information system that tracks information related to the level of care, unmet needs, and service plans. CCU managers supervising the work of individual care coordinators use eCCPIS to monitor that service planning and service initiation are timely and appropriate; CCU managers have ready access to individual participant files to compare against problems identified through the eCCPIS. In addition, all CCP Event Reports (which include critical incidents and complaints) are reviewed and acted upon by the CCU.

IDoA implemented a participant survey process, beginning October 1, 2009, that includes domains assessing participants' perception about the adequacy of their service plan. This effort uses the Participant Outcome and Satisfaction Measures (POSM), a statistically reliable and valid tool developed by the University of Michigan. Individual care coordinators administer this survey during completion of assessment and reassessment (at least annually). All survey data is entered into the State's database. IDoA is responsible in aggregating the data and incorporating results into the quarterly management reports.

IDoA tracks the performance of CCUs and care coordinators in management reports using data generated from the eCCPIS, the CCP event report system, participant survey information, and comparisons of paid services (claims/payment system) with authorized service levels. These management reports address the level at which CCUs and individual care coordinators are meeting the performance indicators in the State's quality improvement plan. One purpose of these quarterly reports is to assist CCUs in improving performance. The reports additionally inform the CCUs and care coordinators how their performance compares to other CCUs. Areas in which there is a pervasive problem across CCUs may indicate systemic problems to be collectively addressed by IDoA, HFS, and CCUs.

IDoA performs an annual desk audit for each CCU. The desk audit includes a review of individual CCU policies and procedures, the past year's management report information, and additional information supplied by the CCU at the request of the State. At least every three years the State performs an on-site review.

IDOA reviews all Department policy and procedures on an ongoing basis and sends to the appropriate agencies within the CCP network. These policies are reviewed by OA staff before a contract is awarded and then again at the time of complaince reviews and at contract renewal. Contracts are on a six-year renewal cycle.

The Medicaid agency, HFS, will conduct routine programmatic and fiscal monitoring for both the OA and the MCOs. For those functions delegated to the OA and the MCOs, the MA is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by the MCOs. The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The MA will pull the sample annually and adjust the methodology as additional MCOs are enrolled to provide long term services and supports.

For the OA, HFS conducts routine program and fiscal monitoring of the waiver program from a selected sample of participants claims. HFS annually conducts focused onsite reviews and statewide randomly selected record reviews. This includes a review of service plan development and implementation assurances.

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit

quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS' contracts with Integrated Care Program MCOs that provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc. Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants enrolled in an MCO. During its record reviews, the EQRO will examine enrollee records and service plans to identify if the participants received services in the type, scope, duration, and frequency as specified in the service plan. Those enrollees who did not receive services in the type, scope, duration, and frequency as specified will be identified and remediation will follow.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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 is described below. In general the State requires a 30-day remediation time frame for issues impacting health, safety and welfare of participants. A 60-day remediation is generally required for those issues that do not.

17D: If plans do not address required items, the OA/MA will require plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.

18D: The OA and MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.

19D: The OA and MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify the need for system improvement.

20D: If plans do not address required items, the MA will require plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.

21D: If plans do not address required items, the MA will require the plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.

22D: If plans do not address required items, the MA will require that the plans be corrected and provide training of case managers. Remediation must be completed within 60 days.

23D: If plans are not signed by appropriate parties within required timeframes, the MA will require the plans be corrected. The MCO may also provide training in both cases. Remediation must be completed within 60 days.

24D: If participants do not receive annual contact by case manager, the MA will require the participant be contacted and provide training of case managers. Remediation must be completed within 60 days.

25D: If service plans are untimely, the OA/MA will require completion for overdue service plans and justification from the case manager. If service plans are not updated when there is documentation that a participant's needs changed, the OA/MCO will require an update. In both cases the OA/MCO may also provide training of case managers. Remediation within 60 days.

26D: If services are initiated untimely, the OA/MA will require the plan be initiated and justification from the case manager. The OA/MCO may also provide training of case managers. Remediation within 60 days.

27D: If utilized services are less than 80% of authorized, the OA/MA will require the CM to review the SP with the participant to ensure all needs are being met. The OA/MCO may also provide training of case managers. Remediation within 60 days.

28D: If monthly contact is not completed for a participant which the CCU has billed for intensive monitoring, the OA will void the federal claim. The OA will determine whether the service was indicated. If not, the OA will revise customer service plan. Remediation must be completed within 30 days.

29D: The OA and MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for

system improvement.

30D:The OA and MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.

31D: If a participant does not receive services as specified in the service plan, the OA/MCO will determine if a correction or adjustment of service plan, services authorized, or services vouchered is needed. If not, services will be implemented as authorized. The OA/MCO may also provide training to case managers. If the issue appears to be fraudulent, it will be reported by the OA/MA to fraud control. Remediation must be completed within 60 days.

32D: The OA/MCO will assure that all waiver participants completed and signed freedom of choice section of the CCP Consent Form. The OA/MCO may also provide training to case managers. Remediation must be completed within 60 days.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

○ **No**

◉ **Yes**

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

The components of assuring service plans is in place with the exception of three items: 1) the use of the annual participant survey mentioned (POSM) and 2) the addition of a data field in eCCPIS to indicate that the informed choice document has been signed, and 3) an automated case note tracking system. It is expected that all three of these items will be implemented during Year 1 of the waiver renewal.

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

E-1: Overview (2 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 (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

E-1: Overview (12 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 (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.

Community Care Program/OA

Any individual who applies for or receives waiver services has the right to Appeal a decision, action or inaction of IDoA, a Case Coordination Unit (CCU) or a provider. The individual is notified by the CCU of his/her right to Appeal any time that action is taken regarding services or eligibility. In addition, the individual is given an explanation of the right to Appeal at the time of the initial home visit and upon request.

A copy of the rights and responsibilities of a CCP applicant/participant (including an explanation of the right to Appeal) is provided in written format to all individuals during the initial home visit for eligibility determination and upon request. Individuals can file an Appeal by contacting the Senior HelpLine or the CCU. They must complete and return to IDoA an official written "Notice of Appeal" form. IDoA then conducts an informal Appeal review within 60 days of receipt of the form. If the Appeal is denied at informal review and the individual does not submit a withdrawal,the Appeal automatically proceeds to a formal hearing.

Fair Hearing by MA

A hearing officer with the Department of Healthcare and Family Services conducts the formal hearing. At the formal hearing, the individual is allowed to present evidence on his/her behalf to dispute the adverse action. The individual may choose to be represented by legal counsel or another person the individual appoints. The decision of the formal hearing is final and can only be Appealed through the circuit court system.

Participants who have filed an Appeal are notified that services will continue through the Appeal process via the IDOA Appeal action notice, which states that the level of service is being continued until the Appeal is complete. Fair hearing documents, including notices of adverse actions and requests for a Fair Hearing, are maintained by IDoA.

Advocacy

Beginning on December 1, 2013, the IDoA Long Term Care Ombudsman Program (LTCOP)expanded services to provide ombudsman services to individuals receiving managed care services, and who are living in community based settings. The LTCOP protects and promotes the rights and quality of life for people who reside in long-term care facilities. The expansion of LTCOP services now makes ombudsman services available to home and community settings.

Program coverage includes seniors aged 60 and older, and disabled adults between the ages of 18-59. The target population includes beneficiaries of the Medicare/Medicaid Alignment Initiative, in addition to individuals receiving Medicaid waiver

services. Individuals participating in these programs have the option of ombudsman assistance when they Appeal a decision made on their case.

Managed Care Organizations

Participants enrolled in an MCO may file for an internal Appeal with the MCO and also have the right to request a fair hearing with final decision being made by the MA. The MA's fair hearings process is the same for all participants, including those enrolled with MCOs. The Medicaid Agency is the final level of Appeal.

MCOs are required to have a formally structured Appeal system that complies with Section 45 of the Managed Care Reform and Patient Rights Act and 42 C.F.R. 438 to handle all Appeals subject to the provisions of such sections of the Act and C.F.R. (including, without limitation, procedures to ensure expedited decision making when an Enrollee's health so necessitates and procedures allowing for an external independent review of Appeals that are denied by the Plan). The State reviews/approves the MCO's Appeal process guidelines.

MCO Internal Appeal Process

The Plans have a separate Appeal process that occurs prior to the Fair Hearing process. An Enrollee or an authorized representative with the Enrollees written consent may file for the internal Appeal or a Fair Hearing. MCOs are required to provide assistance to Enrollees in filing an internal Appeal or in accessing the fair hearing process including assistance in completing forms and completing other procedural steps. This includes providing interpreter services, translation assistance, assistance to the hearing impaired (including toll-free numbers that have adequate TTY/TTD) and assisting those with limited English proficiency. The MCO must make oral interpretation services available free of charge in all languages to all Enrollees who need assistance.

At the time of the initial decision by the MCO to deny a requested non-participating provider, deny a requested service or reduce, suspend or terminate a previously authorized service, a notice of action is provided by the MCOs in writing to the Enrollee and authorized representative, if applicable. In addition, the MCOs provide an Appeal resolution letter, which is also a notice of action, to the Enrollee at the time of the internal grievance or Appeal resolution. If the resolution is not wholly in favor of the Enrollee, the Enrollee may elect to request a fair hearing from the Medicaid agency. The Appeal resolution letter includes the description of the process for requesting a Fair Hearing. If an Appeal is upheld by the Plan, the Plan sends an Appeal decision letter. This letter contains instructions/information on the Fair Hearing process.

Fair Hearing by MA

MCOs inform Enrollees about the participant/enrollee of his/her rights under the MA's Fair Hearing processes. These processes are defined in the member handbook distributed at the time of enrollment. Information about the fair hearing process is also on the MCOs website. The same information is provided whenever an Enrollee makes such a request. An Enrollee may appoint a guardian, caretaker relative, Primary Care Provider, Women's Health Care Provider, or other Physician treating the Enrollee to represent the Enrollee throughout the Appeal process.

The Plan informs the enrollee about their Appeal and fair hearing rights verbally and in writing at the initial face-to-face visit with the enrollee, at least annually, and as needed. Participants may Appeal if services are denied, reduced, suspended, or terminated. In addition, Appeals may be made any time the Plan takes an action to deny the service(s) of the enrollee's choice or the provider(s) of their choice; The Appeal process is described in writing in the Plan's member handbook which is reviewed with the participant by the Plan's case manager.

When services are denied, reduced, suspended, terminated, or choice is denied, the member is informed via a Notice of Action Letter. This notice includes (a) A statement of what action the Plan intends to take; (b) The reasons for the intended action; (c) The guidelines or criteria used in making the decision.

The Notice of Action also contains information on appealing the determination and how services can continue during the period while the participant's Appeal is under consideration. Participants who have filed an Appeal are notified that services will continue through the Appeal process via the IDOA Appeal action notice, which states that the level of service is being continued until the Appeal is complete.

Reporting

Each MCO submits a monthly Grievances and Appeals detail report and a quarterly Grievance and Appeals summary report to the MA. The format of each report is dictated by the MA. The monthly reports provide a record of Appeals requests in detail, including a description of each Grievance and Appeal, dates, outcome, incident summary, and resolution summary. This quarterly summary report of Grievances and Appeals filed by Enrollees, is organized by categories of

medical necessity reviews, access to care, quality of care, transportation, pharmacy, LTSS services and other issues. It includes the total grievance and Appeals per 1,000 Enrollees for their entire MMAI population. Additionally, it includes a summary count of any such Appeals received during the reporting period including those that go through Fair Hearings and external independent reviews. Finally, these reports include Appeals outcomes- whether the Appeals were upheld or overturned. Appeals are reported separately for each Waiver. HFS reviews and analyzes the grievance and Appeals reports. HFS compares the reports among plans over time and across plans to analyze trends, outliers among plans and to assure that the plans are addressing areas of concern. Records of adverse actions and requests for Appeals are maintained by the MCOs for a period of six (6) years.

The State ensures that managed care enrollees, including those that receive waiver servies are informed by the MCO about their Fair Hearing Process by reviewing and prior approving the Enrollee Handbook, Notice of Action, and any Appeal letters which must contain the enrollees' rights to a Fair Hearing and how to request such. The States EQRO also reviews such documents through a desk review and determines if the MCO is compliant during on-site visits. The State reviews/approves the MCO's Appeal process guidelines. Copies of the Notice of Action documents, including notices of adverse actions and the opportunity to request a Fair Hearing, are maintained by the Plan in a database.

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:

IDoA operates the grievance and complaint system in cooperation with its contracted agencies. If participants file a grievance or complaint, they are informed that filing a grievance or complaint is not a prerequisite or substitute for a an Appeal and Fair Hearing.

For participants enrolled in an MCO, the Plans have established and maintain a procedure for reviewing Grievances registered by Enrollees.

Each MCO is required to establish and maintain a procedure for reviewing grievances (any expression of dissatisfaction about any matter other than an action) registered by Enrollees. All Grievances are registered initially with the MCO and may later be appealed to the MA 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).

Community Care Program/OA

Any participant or interested person may communicate a complaint through the State's Senior Helpline, a CCU, a care coordinator, or a provider. In addition, the Ombudsmen Program has been expanded for advocacy on behalf of participants enrolled in managed care. The State has defined complaints as any oral or written communication by the participant or other interested party expressing dissatisfaction with the eligibility, operation or provision of service (or lack therof), service quality, or service staff.

The information from a complaint is recorded as a CCP Event, using the Event Report Form. The data is placed into a statewide database. The lodged complaint is sent to the CCU in the area where the individual participant resides for investigation. The CCU is required to review the complaint and to resolve the issue within fourteen days, unless there are documented circumstances that preclude resolution within that timeframe. Mechanisms to resolve the complaint include the CCU working with the individual, their family, and provider agencies to address the problem.

In cases where the CCU is either the subject of the complaint or a complaint cannot be resolved, IDoA reviews the complaint. IDoA reviews the information and determines appropriate actions to be taken.

If the complaint involves a provider or CCU failure to meet expectations, IDoA has authority to issue a corrective action plan, to suspend new referrals, apply fines, cancel a contract, or take other appropriate action in accordance with 89 Ill. Adm. Code 240.1665.

Complaints are tracked in the Event reporting system. IDoA includes information about complaints in its quarterly management reports shared with HFS, CCUs, care coordinators, and provider agencies.

Managed Care Organization

For participants enrolled in an MCO, all grievances shall be registered initially with the Plan and may later be appealed to the MA. The Plan's procedures must: (i) be submitted to the MA in writing and approved in writing by the MA;(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 internal informal system used to attempt to resolve all grievances;
• A Grievance system that has a formal structure compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 C.F.R. 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 so necessitates);
• A Grievance system that has a formal structure that is available for Enrollees of the Plan when his/her Grievances cannot be handled informally and do meet the expectations of the procedures set-up under the Managed Care Reform and Patient Rights Act. All Enrollees must be informed that a Grievance system and its processes exist. Grievances that meet the expectations the Act, must be in writing and sent to the Grievance Committee for review;
• The composition of the Grievance Committee must include at least one (1) Plan enrollee on the Committee. The MA may require that one (1) member of the Grievance Committee be a representative of the MA;
• Final decisions under the Managed Care Reform and Patient Rights Act procedures and those of the Grievance Committee may be appealed by the enrollee filing the Grievance to the MA 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 MA quarterly; and
• An enrollee may appoint a guardian, caretaker relative, PCP, WHCP, or other Physician treating the enrollee to represent the Enrollee throughout the Grievance process.

The state has provided that individuals must first avail themselves of the internal Grievance and Appeals processes before accessing the Fair Hearings process. Enrollees are notified of these expectations through the Enrollee Handbook, the Notice of Action, and any Appeal letters. Plans also discuss the Grievance and Appeals process with the Enrollee during the service planning process.

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 Illinois Department on Aging (IDoA) operates two critical event systems. For critical events that involve participant abuse, neglect and exploitation (ANE), there is an ANE reporting system under Adult Protective Services program. For other types of incidents there is a separate reporting process. These other types of incidents do not meet the level of ANE.

Adult Protective Services

The processes defined under Adult Protective Services are the same whether the waiver participant receives care coordination through CCUs or through managed care.

Public Act 94-1064 amended the Elder Abuse and Neglect Act, changing the name of the entity to Adult Protective Services which had the effect of expanding the former elder abuse program to all adult populations. In addition, Adult Protective Services Act (320 ILCS 20/1 et seq.) authorized IDoA to administer the Adult Protective Services unit (APS) to respond to reports of abuse for all non-institutionalized adults. The empowered APS unit provides investigation of allegations and intervention and follow-up services to victims. It is coordinated through 42 agencies located throughout the state and designated by the Area Agencies on Aging (AAA) and IDoA. The contracts for this service and training are separate from IDoA contractual agreements for CCU care coordination services and CCP training. However, many of the CCUs are also designated APS agencies. The APS agencies conduct investigations of allegations of abuse and work adults, including those covered by the waiver in resolving abusive situations. Persons can report suspected abuse, neglect or exploitation to IDoA by utilizing the APS Hotline number at 1-866-800-1409, available 24 hours a day, seven days a week.

Definitions of ANE

The State uses a set of definitions for critical incidents covering abuse, neglect, exploitation and other events that can place an individual at risk. These definitions can be found at 89 ILAC Section 270.210.
The APS responds to the following types of abuse:
• Physical abuse means inflicting physical pain or injury upon an adult
• Sexual abuse means touching, fondling, intercourse, or any other sexual activity with an adult, when the adult is unable to understand, unwilling to consent, threatened or physically forced.
• Emotional abuse means verbal assaults, threats of maltreatment, harassment or intimidation.
• Confinement means restraining or isolating an adult, other than for medical reasons.
• Passive neglect means the caregiver's failure to provide an adult with life's necessities, including, but not limited to, food, clothing, shelter or medical care.
• Willful deprivation means deliberate denial of an adult medication, medical care, shelter, food, a therapeutic device, or other physical assistance and thereby exposing that person to the risk of physical, mental or emotional harm- except when the adult has expressed capacity to understand the consequences and intent to forego such care.
• Financial exploitation means the misuse or withholding of an adult's resources by another to the disadvantage of the adult person, or for the profit or advantage of someone else.
Substantiated case means a reported case of alleged or suspected abuse, neglect, financial exploitation, or self-neglect

in which a provider agency, after assessment, determines that there is reason to believe abuse, neglect, or financial exploitation has occurred.

Adult abuse refers to the following types of mistreatment to any Illinois resident age 18-59 living with a disability or an adult 60 years of age or older who lives in a domestic setting. The abuse must be one of the following types and must be committed by another person.

Abuse means physical, sexual or emotional maltreatment or willful confinement.
Neglect means the failure of a caregiver to provide an adult with the necessities of life, including, but not limited to food, clothing, shelter or medical care. Neglect may be either passive (non-malicious) or willful.
Financial exploitation means the misuse or withholding of an adult's resources by another to the disadvantage of the adult or the profit of another.

State regulations covering APS, mandated reporting, and timelines are contained in 89 Illinois Administrative Code (ILAC), Part 270.

Mandated Reporters

The Illinois Adult Protective Services Act (320 ILCS 20/1) requires personnel of IDoA and its constituent AAA and provider agencies to be mandated reporters in cases where the adult is unable to self-report. IDoA policy specifically states that if a direct service worker witnesses or identifies a case of possible abuse or neglect, they are mandated to personally report the allegations to the designated APS agency or to IDoA's Hotline number. IDoAs Office of Adult Protective Services maintains a tracking system of ANE investigations and statistical reports are generated annually. Mandated Reporting and timelines for reporting can be found at: 89 ILAC, Section 270.230.

Elder Abuse Reporting

More information and brochures [Adult Protective Services Act and Related Laws and What Professionals Need to Know] may be found at: http://www.illinois.gov/aging/ProtectionAdvocacy/Pages/abuse.aspx

Reporting Timelines

Follow-up Actions by IDoA can be found at: 89 ILAC, Section 270.240 Intake of ANE Reports
Rules may be accessed at the OA's website at:
http://www.illinois.gov/aging/AboutUs/Pages/rules-main.aspx

Other Incidents Other Critical Incidents including those resulting in Death or Injury not related to ANE

For instances of alleged provider or CCU action/inaction leading to reported death or injury (but not due to suspected abuse or neglect), a verbal report must be submitted within twenty-four (24) hours to the Department, Division of Home and Community Services, Office of Community Care Services. The Provider or CCU must immediately follow-up on any such allegation and provide a written report to the IDoA's Division of Home and Community Services, within five (5) work days of the incident. When a participant death or injury resulting in the need for medical care occurs during the provision of CCP services, the Provider must notify the CCU and the Division of Home and Community Services within 5 work days of the incident. Upon notification from the Provider of an incident, the CCU investigates the circumstances by completing follow-up phone calls to the participant/authorized representative and any actions taken as a result of these conversations. The CCU must document these follow-up contacts and submit documentation to the Division of Home and Community Services within 10 work days of the incident. Upon receipt of injury and/or death reports from the Provider and CCU, Division of Home and Community Services staff will maintain follow-up communication with both agencies as long as pertinent activity either exists or is necessary.

Service Improvement Reporting (SIP)

When a Provider or CCU receives a complaint and/or problematic issue, they are to mutually attempt resolution. Complaints and/or problematic issues that are not able to be resolved may be documented on the Service Improvement Program Reporting Form (SIP) and faxed or mailed to the Department's Senior HelpLine within two (2) calendar days. SIPs are to be either resolved or a plan for resolution must be developed within fifteen (15) calendar days from the date of the SIP report. Both the CCU and provider agency must provide the Department with a completed SIP report/response form within twenty (20) calendar days of the report to the Senior HelpLine. Department Division of Home and Community Services staff review SIP responses and may intervene to assure appropriate resolutions have occurred.

For participants enrolled in an MCO, the Plan are required to comply with all health, safety and welfare monitoring and reporting required by State or federal statute or regulation, or that is otherwise a condition for a HCBS Waiver, including, but not limited to, the following: critical incident reporting regarding Abuse, Neglect, and Exploitation; critical incident reporting regarding any incident that has the potential to place an Enrollee, or an Enrollee's services, at risk, but which does not rise to the level of Abuse, Neglect, or Exploitation; and performance measures relating to the areas of health, safety and welfare and required for operating and maintaining a HCBS Waiver. As such, the Plans comply with the Illinois Adult Protective Services Act (320 ILCS 20/1).

For critical incidents that are not defined as Abuse, Neglect and/or Exploitation, the Plans have internal processes that are not limited to, but include death, suspicious death, falls, serious physical injury, hospital admission, misuse of funds, Misuse of funds, medication error, unauthorized use of restraint, seclusion or restrictive physical or chemical restraints, elopement or missing person, fires, severe natural disaster, possession of firearms (participant or staff), possession of illegal substances (participant or staff), criminal victimization, financial exploitation, and suicide or attempted suicide.

For these types of incidents, if there is a perceived immediate threat to a member's life or safety, the Plan is to follow emergency procedures which may include calling 911.

All incidents are reported to the compliance officer or designee and entered in to the Plans Critical Incidents report database. Based on situation, the enrollee/members age and placement reports will also be made to the appropriate State of Illinois investigative agencies.

The Plans continues to 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 or support.

Also, the Plans assure that HCBS waiver agencies, providers and workers (including care coordinators) are well informed of their responsibilities to identify and report all critical incidents. These responsibilities are 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.

Individuals and families are provided information from the CCU at the time of the initial assessment and annual rerassessment/redetermination on ANE and how to report other critical incidents. Training also covers the occurrence of assigned caregiver/workers not showing-up for service delivery. The State also requires the care coordinator to address with program participants issues of privacy, safety, and respect during administration of the State's consumer survey. This survey occurs during the assessment/reassessment process.

The need for general public awareness has been addressed through campaigns, "Break the Silence" and B*SAFE (Banks and Seniors Against Financial Exploitation). These public awareness campaigns, facilitated through APS, provide information and training about how to prevent and to recognize situations involving abuse, neglect, and exploitation ofall adults including older adults.

Care coordinators receive training as part of the IDoA required training for all care coordinators on critical incident reporting and follow-up. Direct care staff is provided training through their employer and new state provider standards have enhanced requirements for staff training about abuse, neglect, exploitation, and mandated reporting requirements. As stated above, CCU and direct care staff are mandated reporters for abuse, neglect, and exploitation. IDoA receives ANE through the APS hotline and other complaints and incidents through the Senior Helpline..
For participants enrolled in an MCO, the Plan trains all of its employees, Affiliated Providers, Affiliates and subcontractors to recognize potential concerns related to Abuse, Neglect and Exploitation, and on their responsibility to report suspected or alleged Abuse, Neglect and/or Exploitation. The Plan's employees who, in good faith, report suspicious or alleged Abuse or Neglect shall not be subjected to any adverse action from the Plan, its Affiliated Providers, Affiliates or subcontractors.

Providers, Enrollees and Enrollees' family members are trained about the signs of Abuse, Neglect and Exploitation, what to do if they suspect any of these actions to be taking place. In addition, they are informed of the Plan's responsibilities in regards to all critical incidents. Training sessions are customized to the target audience. Training includes general indicators of Abuse, Neglect and Exploitation and the timeframe requirements for reporting.

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.

During year one of the waiver renewal, IDoA anticipates the implementation of a web-enabled system to receive all reports of critical incidents as part of its Event Reporting system. Providers and care coordinators will enter incidents directly into the secured website. Participants, family members and others may call the State's Senior Helpline: 1-800-252-8966 or the 24-Hour Adult Protective Services Hotline: 1-866-800-1409. APS
IDoA, the CCU and the care coordinator are notified of incidents in all cases. Depending on the nature of the incident of Abuse and Neglect and Exploitation (ANE), the participant and/or family members, and providers may be notified. The State has set criteria regarding when notifications are mandatory or are at the discretion of the care coordinator.

IDoA has established classifications for critical incidents (i.e., Priority I, II, III,) depending upon the nature and urgency of the event. This classification determines whether an investigation needs to occur in the timeframe for conducting that investigation. The definitions and time frames of these levels are located at 89 ILAC Section 270.240
Responding to Reports –
Depending on the nature and seriousness of the allegations, a trained caseworker makes a face-to-face contact with the alleged victim with the following time frames:

•Priority One – Reports of abuse or neglect where the alleged victim is reported to be in imminent danger of death or serious physical harm. The caseworker must make a face-to-face visit within 24 hours.

•Priority Two – Reports that an alleged victim is being abused, neglected, or financially exploited and the report taker has reason to believe that the health and safety consequences to the alleged victim are less serious that priority one reports. The caseworker must make a face-to-face visit within 72 hours.

•Priority Three – Reports that an alleged victim is being emotionally abused or the alleged victim's financial resources are being misused or withheld and the report taker has reason to believe that there is no immediate or serious threat of harm to the alleged victim. The caseworker must make a face-to-face visit within 7 calendar days of the receipt of the report.

The State requires that all Priority I incidents be at least temporarily corrected within 24 hours and a permanent correction must occur within 60 days. All other events must be corrected within 60 days. The State's Office of Adult Protective Services' regulations also require certain response timelines by the ANE agency. These are located at 89 ILAC Part 270.

The Event Reporting system also tracks the status of any investigation and follow-up actions taken. The State has established criteria regarding when the CCU must conduct a review, when an on-site visit must occur, and when the change of status assessment must occur.

The CCU is responsible to ensure the health and welfare of the participant and may authorize additional services, such as intensive care coordination, to protect the welfare of the individual. Critical incidents may also result in a review of participant needs to determine whether a change in the service or level of service is needed.

APS Reporting

State requirements for reporting of abuse, neglect or financial exploitation of participants' age 60 years and older are as follows:

The Illinois Department on Aging (ID0A) Office of Adult Protective Services administers the Abuse, Neglect and Financial Exploitation Program (ANE), which responds to alleged abuse, neglect or financial exploitation of persons 60 years of age and older who reside in the community. The program provides investigation, intervention and follow-up services to victims. It is locally coordinated through 42 agencies designated by the Area Agencies on Aging (AAA) and IDoA. The Adult Protective Services Agencies conduct investigations and work with older adults in resolving abusive situations.

Abuse Hotline Number:

866-800-1409 (voice): available 24 hours a day, seven days a week
888-206-1327 (TTY)

Other Critical Incidents – Deaths or Injury not related to ANE

For instances of alleged provider or CCU action/inaction leading to reported death or injury (but not due to suspected abuse or neglect), a verbal report must be submitted within twenty-four (24) hours to the Department, Division of Home and Community Services, Office of Community Care Services. The Provider or CCU must immediately follow-up on any such allegation and provide a written report to the Division of Home and Community Services, within five (5) work days of the incident. When a participant death or injury resulting in the need for medical care occurs during the provision of CCP services, the Provider must notify the CCU and the Division of Home and Community Services within 5 work days of the incident. Upon notification from the Provider of an incident, the CCU must complete follow-up phone calls to the participant/authorized representative. The CCU must document these follow-up contacts and submit documentation to the Division of Home and Community Services within 10 work days of the incident. Upon receipt of injury and/or death reports from the Provider and CCU, Division of Home and Community Services staff will maintain follow-up communication with both agencies as long as pertinent activity either exists or is required.

Service Improvement Reporting (SIP)

When a Provider or CCU receives a complaint and/or problematic issue, they are to mutually attempt resolution. Complaints and/or problematic issues that are not able to be resolved may be documented on the Service Improvement Program Reporting Form (SIP) and faxed or mailed to the Department's Senior HelpLine within two (2) calendar days. SIPs are to be either resolved or a plan for resolution must be developed within fifteen (15) calendar days from the date of the SIP report. Both the CCU and provider agency must provide the Department with a completed SIP report/response form within twenty (20) calendar days of the report to the Senior HelpLine. Department Division of Home and Community Services staff review SIP responses to assure appropriate resolutions have occurred.

For participants enrolled in an MCO, the Plans 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 include processes for ensuring participant safety while the State authority conducts its investigation.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The OA, IDoA oversees the reporting and response of all critical incidents and complaints. IDoA tracks this through its CCP Event Report system. IDoA reviews information about all critical event reports and activities at least quarterly. For some individual circumstances, the IDoA may be working with ANE or the CCU to resolve the issue.

All critical event data are integrated into the quarterly management reports used by IDoA and HFS to monitor system performance and remediate problems. CCUs and care coordinators will receive information in their quarterly performance reports about critical events involving CCP recipients for whom they are responsible. IDoA and the CCUs also review statewide and regional performance at quarterly meetings.

For participants enrolled in 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 is included in the reporting requirements to the MA. The MA monitors both compliance of performance measures and timeliness of remediation for those waiver participants enrolled in an MCO. Participants in MCOs are included in the representative sampling.

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:

IDoA and CCU agencies are responsible for detecting the unauthorized use of restrictive interventions. Their oversight includes:

1.CCU and care coordinator reviews of all CCP Event Reports involving the use of restrictive interventions.

2.IDoA will review instances of restrictive interventions reported through event reports that are outside the restraint and seclusion policy.

3.During Quality Improvement reviews, IDoA will review documentation of instances of restraint and seclusion to verify that restrictive interventions were not used.

For participants enrolled in an MCO, the Plans are responsible to detect the unauthorized use of restrictive interventions. Events involving the use of restrictive interventions are reported to the Plan as a reportable incident, and reported to the investigating authority as indicated.

The MCOs and OA are to detect unauthorized use of restraints and/or seclusion through face-to-face visits, routine contacts with the participants, and through complaint or incident reporting. The case coordinators are responsible for the overseeing the waiver participants 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:

IDoA and CCU agencies are responsible for detecting the unauthorized use of restrictive interventions. Their oversight includes:

1.CCU and care coordinator reviews of all CCP Event Reports involving the use of restrictive interventions.

2.IDoA will review instances of restrictive interventions reported through event reports that are outside the restraint and seclusion policy.

3.During Quality Improvement reviews, IDoA will review documentation of instances of restraint and seclusion to verify that restrictive interventions were not used.

For participants enrolled in an MCO, the Plans are responsible to detect the unauthorized use of restrictive

interventions. Events involving the use of restrictive interventions would be reported to the Plan as a reportable incident, and reported to the investigating authority as indicated.

The MCOs and OA will detect unauthorized use of restraints and/or seclusion through face-to-face visits, routine contacts with the participants, and possibly through complaint or incident reporting. The case managers will be responsible for the overseeing the waiver participants and assuring their health, safety, and welfare.

○ **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:

Care coordinators through their regular contact monitor for all activities that appear to fall under abuse, neglect and exploitation. Seclusion would fall under this category. In addition, all providers are trained to monitor similar activities. Reports of abuse, neglect and exploitation, including seclusion are to be made to the Adult Protective Services Unit for investigation.

○ **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.

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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. **Medication Administration by Waiver Providers**

Answers provided in G-3-a indicate you do not need to complete this section

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).

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:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

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.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*
   i. **Sub-Assurances:**
      a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
42G: # and % of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately taken by the MCO. N:# of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately taken by the MCO. D:Total # of MCO participants for whom identified critical incidents were reviewed.

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

Data Aggregation and Analysis:

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

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

Performance Measure:
36G: Participants indicate a positive response (average score of at least 4) when asked about security.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; POSM Survey

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
38G: Participants indicate a positive response (average score of at least 4) when asked about being treated with dignity and respect.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports/POSM Survey

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

Specify: MCO		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
37G: Participants indicate a positive response (average score of at least 4) when asked about privacy.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports/POSM Survey

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

		Confidence Interval =
☑ **Other** Specify: MCO	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

Performance Measure:
34G: Complaints reported using the CCP Event Document or the MCO critical events reporting system are resolved by the care coordinator within the required fourteen day period unless the CCU or MCO provides rationale for why remediation will take longer.

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

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

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

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

Data Aggregation and Analysis:

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

☑ **Other** Specify: MCO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
41G: # and % of restraint applications, seclusion, or other restrictive interventions where appropriate intervention by the MCO occurred. N:# of restraint applications, seclusion, or other restrictive interventions where appropriate intervention by the MCO occurred. D:Total # of MCO restraint applications, seclusion, or other restrictive intervention.

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

Data Aggregation and Analysis:

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

Performance Measure:
35G: Providers comply with background check requirements for all direct service employees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Staff training tracking system

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

Data Aggregation and Analysis:

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

Performance Measure:
33G: 100% of CCP participants having a reported abuse or neglect report will receive a CCU or MCO review within State required timelines as a way to assure the health, safety, and welfare of the participant.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CCP Event Report

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; EQRO Reviews

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**

☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: MCO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
40G:# and % of participants' deaths as a result of substantiated case of abuse, neglect or exploitation where appropriate follow-up actions were implemented by the MCO. N:# of deaths as a result of a substantiated case of A/N/E where appropriate follow-up actions were implemented by the MCO. D:Total # of MCO deaths as a result of a substantiated case of A/N/E.

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

Data Aggregation and Analysis:

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

Performance Measure:
39G: # and % of participants who received information from the MCO about how and to whom to report abuse, neglect, exploitation at the time of assessment/reassessment. N: # of participant records reviewed where the participant received information from the MCO about how and to whom to report A/N/E at the time of assessment/reassessment. D: Total # of MCO participant records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; EQRO Reports

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

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.

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.

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.
IDoA has a three-prong approach to address health, safety and welfare issues.

First, the state obtains a direct report of potential issues affecting health and safety from the participants. For individual waiver participants, the care coordinator completes an initial and annual assessment to determine needs of the participant (see Service Planning). This process includes using the DON to identify unmet needs and administering the POSM, a participant survey tool. Some of the POSM questions pertain to the individual's perceptions of safety, privacy, and respectful treatment. The care coordinator addresses problems identified during the assessment process or survey administration either as a service planning issue or a CCP event report. IDoA tracks information from the assessment and event reports through its eCCPIS and CCP Event Report systems. Care coordinators are required to follow-up with any participants reporting that they did not feel safe, that their privacy is not respected, or they are not treated with respect. Care coordinators supervisors monitor the care coordinators performance in these areas. IDoA also monitors the performance of the CCUs.

Second, the state's approach screens-out individuals with criminal backgrounds who seek employment with providers. Provider staff, in addition to meeting educational and training requirements for a job, must undergo a background check as part of the conditions of employment. Providers are responsible to complete the background check, maintain information in the employee file, and enter verification in the training tracking database. IDoA audits for compliance with this requirement when completing quarterly management reports, during the provider audit, and the documentation is verified during the onsite reviews.

Finally, the approach maintains a system to intervene and remediate reported incidents and complaints. IDoA maintains a CCP Event Report system to deal with critical incidents or complaints involving CCP participants. A critical incident includes a range of defined events that negatively impact the health and welfare of a waiver participant. These events are classified within one of four levels of intensity, depending on the nature of the incident and the level of risk posed. A complaint includes any oral or written communication by the participant or other interested party expressing dissatisfaction with the operation or provision of service, service quality, service staff, or a failure to provide/offer services.

Any person can report a critical incident or make a complaint by contacting the state's Senior Helpline, a CCU, or a provider. The state uses a CCP Event system to record information. The Senior Helpline can enter data. After a CCP event is reported, the CCU receives notice and is responsible to review each incident or complaint. If the report includes suspected abuse, neglect, or exploitation, the state's Adult Protective Service (APS) agency is immediately notified so that it may begin its investigation as required by Illinois Elder Rights regulations.
The state has developed a protocol to deal with CCP reports of critical incidents and complaints. The protocol defines timelines, notification requirements, referrals, and follow up steps. All critical incidents and complaints must be resolved within State set timelines, unless there are documented circumstances that preclude a resolution within this timeline. If resolution is not immediately forthcoming, the CCU is responsible to continue to ensure the health and welfare of the individual during this time.
The Medicaid agency, HFS, conducts routine programmatic and fiscal monitoring for both the OA and the MCOs.

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

The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The MA pulls the sample annually and adjust the methodology as additional MCOs are enrolled to provide long term services and supports. For critical incidents, the MCOs are required to report 100% of the findings and remediation. These reports are summarized by the Plans and reported at least quarterly to the MA.

For the OA, reviews include compliance with employee background checks. Prior to and during onsite provider reviews, HFS reviews related critical event reports.

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS' contracts with Integrated Care Program MCOs that provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc. Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants enrolled in an MCO through consumer surveys and quarterly record reviews. Participants in MCOs are included in the representative sampling.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
33G: The Case Manager to perform a review on all participants having a A/N/E report which did not receive a review within State required timelines. The OA/MCO may also provide training to case managers. Remediation must be completed within 30 days.

34G: OA Care Coordinator/MCO Case Manager to provide rationale for complaints not resolved in 14 days. Remediation will be completed within 30 days.

35G: Remove as a Medicaid provider in MMIS and request the respective provider background check. Change of provider; Training for OA case managers. Remediation within 60 days.

36G: The OA and MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.

37G: The OA and MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.

38G: The OA and MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.

39G: The MCO will assure that customers know how to report abuse, neglect or exploitation. This will be demonstrated by correction of case work documentation reflecting customers awareness, including evidence of steps taken to educate the customer. Remediation must be completed within 30 days.

40G: The cause of death/circumstances would be reviewed by the MCO and need for training or other remediation; including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns. Resolution or remediation timeframe would be case-specific.

41G: Restraint applications, seclusion, or other restrictive interventions will be reviewed by the MCO. The need for training or other remediation; including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns. Resolution or remediation timeframe would be case-specific.

42G: The MCO will follow up on identified critical incidents, other than A/N/E, to ensure information was reviewed and corrective measures were appropriately taken. Resolution or remediation will be based on the nature of the concern. Survey responses will be used to identify need for system improvement.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

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;
- 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 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency (MA), and the Illinois Department on Aging, as the Operating Agency (OA), and the contracted Managed Care Organizations (MCOs) work in partnership to evaluate the waiver Quality Management System (QMS). This partnership provides analysis to information derived from discovery and collaboratively develops and monitors remediation activities for each of the federal assurances.

For the OA, the IDoA and HFS management reports track changes in performance measures over time. This includes tracking changes across the entire state as well as by region and provider type. This helps to identify problematic areas and potential best practices. IDoA aggregates information and generates these reports on a quarterly basis.
For the OA, the state takes a multi-phased and multilevel approach to using management reports to improve the overall system. Because changes in the performance indicator may be explained by an external factor that would not require remediation (e.g., better targeting of individuals with greater impairment than may have an adverse impact on some of the performance indicators), the first step is to investigate to try to determine if an actual problem exists. The second step is to formulate potential interventions that may remediate the problem. The third step is to roll out those interventions, possibly on a pilot basis. The final step is to track changes using the original performance indicators to assess the impact of intervention.

Because the state's system between HFS and the OA is hierarchical. HFS oversees IDoA, which oversees the individual CCUs, which oversee the individual care coordinators, the process described above must be

multilevel. Consequently, the state's quality management system includes regular and structured oversight meetings to facilitate communication, investigation, and problem solving across the levels. Each CCU is required to have at least monthly quality management meetings with their individual care coordinators. IDoA is meeting with the CCUs as a whole on a quarterly basis, as well as, reviewing the performance of individual CCUs on a quarterly basis and meeting with them on at least an annual basis (and more often if performance is problematic). IDoA and HFS meet on at least a quarterly basis.

The OA and MCO's are responsible for the majority of the data collection to address the Quality Management System discovery and remediation activities. The OA is solely responsible for eligibility and authorizing qualified providers. Therefore, there are distinct performance measures for these functions under the OA. Both the OA and the MCOs are accountable for all other measures. The MA is accountable for the measures in the Administrative Authority appendix. Additional measures have been added under the Administrative Authority appendix that is specific to oversight of the MCOs. The state's system improvement activities are in response to aggregated and analyzed discovery and remediation data collected on each of the waiver performance measures.

On a quarterly basis, the MA conducts separate Quality Management Committee (QMC) meetings with the OA and the MCOs to review data collected from the previous quarter and for the year to date. Data is collected on a regular basis and is reported as indicated by the performance measure in the waiver. All reports will be provided to MA for review prior to the quarterly meetings. Annual reports are produced identifying trends based on the representative sample and/or 100% review of data.

Data will be reported by individual performance measures. Data reported includes: level of compliance and timeliness of remediation based on immediate, 30, 60, 90 day increments and any outstanding remediation. The MCOs may report in a slightly different format than the OA as there are additional performance measures.

During quarterly meetings, the MA and the OA or MCO identify trends based on scope, severity, changes and patterns of compliance by reviewing both the levels of compliance with the performance measures and remediation activities conducted by the OA and the MCOs. Identified trends are discussed and analyzed regarding cause, contributing factors and opportunities for system improvement. Systems improvement is prioritized based on the overall impact to the participants and the program. Systems improvements may be prioritized based on factors such as: the impact on the health and welfare of waiver participants, legislative considerations and fiscal considerations. The OA and the MCOs maintains separate QMC Systems Improvement Logs. Recommendations for system improvements are added to the log(s) for tracking purposes. The OA and the MCOs documents the systems improvement implementation activities on its respective log. The MA assures that the recommendations are followed through to completion. Decisions and time lines for system improvement are based on consensus of priority and specific steps needed to accomplish change. These decisions are documented on the systems improvement log and communicated through the sharing of the quarterly meeting summary and the systems improvement log.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☑ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a

description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

For the OA, the state use the same mechanisms that it uses to identify potential issues including contract compliance, satisfaction surveys, assurances, critical incidents and SIPs to monitor the effectiveness of any and all interventions. The state tracks changes in the performance indicators using management reports.

In the OA section above, the roles of the Medicaid agency (MA), IDoA (OA), the individual CCUs, and the care coordinators are described. For both the OA and MCOs, participant input also plays a central role in the quality management system as follows: 1) Participants perception of the quality of their services using constructs that are meaningful to participants (e.g., integration in the community, dignity, respect, etc.) as gathered through the POSM are used as a central performance indicators. This provides IDoA and the MCOs with the direct feedback loop about the effect of potential interventions on the quality of life for individual participants; and 2) care coordinators share reports with participants and their representatives about how their experience compares to that of other consumers across the state.

As an example, IDoA, the MCOs and HFS monitors trends in participants reports of opportunities for community integration using data gathered from the POSM. The entities may notice a pattern of low scores for certain providers, but high scores for others. This will lead IDoA to query the individual care coordinators about provider practices that may explain this discrepancy. The entities will subsequently use best practices that are identified as a core component of training, in the training of poor performers. IDoA may even collaborate and utilize providers who appear to be performing well on this training. IDoA subsequently tracks the performance of providers who receive this training to assess the efficacy of the intervention.

In the OA waiver quality plan, the State has implemented additional efforts to address its ability to improve and maintain quality. These include:
1) Updated performance measures in each of the waiver areas,
2) Redesigned management reports to be used on a quarterly basis,
3) Updated CCP Event Report system and clearer delineation of critical incident definitions and follow-up procedures,
4) Implementation of training tracking system and a new case note system, and
5) Implementation of two participant survey processes, both of which have been tested for validity and reliability.

IDoA meets with the Community Care Program Advisory Committee (CCPAC) six times a year to present information about the waiver and receive input from providers and participant representatives. The CCPAC has several work groups, including a quality committee. This process of inclusion of stakeholders has been most effective and is viewed by the OA as a critical element in its quality management strategies (QMS).

The processes Illinois follows to continuously evaluatethe effectiveness of the QMS are the same processes to evaluate the information derived from discovery and remediation activities. The Waiver Quality Management Committee (QMC) System Improvement Log is a dynamic product that is discussed quarterly by key staff of the MA and the OA or MCO regarding progress, updates and evaluation of effectiveness. Effectiveness is measured by impact on performance based on ongoing data collection over time, feedback from participant/guardian interviews, satisfaction surveys, and service providers. Multiple years of data collection will allow the State to evaluate the effectiveness of system improvements over time.

System design changes may be specific to the OA, the MCOs, or both. The purpose of meeting with all parties annually is to provide an arena to see the system holistically, determine how well the system design changes are working and what areas require further improvement. Decisions that are made as a result of these meetings are tracked on the QMC Systems Improvement Log.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

During the quarterly meetings with the OA, IDoA and HFS reviews waiver services, management reports, and the Quality Improvement Strategies. The OA and the MA, as partners discuss updates that both Departments need to address in the future. IDOA also seeks input from its advisory groups on improvements and/or changes to the Quality Improvement Strategy. IDOA continually address issues as they arise, respond and implements strategies to effect changes to performance indicators. The whole QMS is viewed as a continuous ongoing process.

One QMC meeting a year is dedicated as a combined meeting with the MA, the OA, and the MCOs. At this

meeting, the entities meet and discuss statewide issues impacting the waiver. During this annual meeting, the OA and the MCOs has on the agenda an overview of the previous year's activities and a discussion of whether changes are needed to the Quality Management Strategy. The MA and the OA see five primary focus areas: These areas are described below.
1) Structure of the QMC: The group reviews the structure of the QMC to determine if it is effective.
2) Trend Analysis: The group evaluates the processes for identifying trends and patterns to assure that issues are being identified.
3) Systems Improvement Log: The group reviews the QMC Systems Improvement Log to assure that all recommendations have been implemented in accordance with agreed upon time lines, and if not, whether there is justification.
4) System Improvement Priorities: The methods for determining system improvement priorities are evaluated to determine effectiveness.
5) Performance Measures: The entities determine whether to make changes in existing performance measures, add measures, or discontinue measures. Other elements of performance measures are reviewed for effectiveness, including: the frequency of data collection, source of data, sampling methodology, and remediation.

The state continuously strives to increase the compliance rate of each performance measure. While the target compliance rate for each performance measure is 100%, the state realizes that it may take multiple system changes over several years to reach the goal of 100% compliance, as well as, all entities involve experience staff changes that require ongoing training.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) Requirements concerning the independent audit of provider agencies;

Independent audits of in-home service provider agencies are required by rule 240.1525(b)(1)-(2). The audits must be conducted annually by an independent Certified Public Accountant and submitted to IDoA for review. Staff in the Bureau of Business Services review the audits and ensure each agency required to complete an audit have done so. Any deficiencies or lack of submitted audit(s) are reported to the Office of Community Care Services who initiate corrective and/or contract action on the provider agency until such time as the deficiency is corrected.

30 ILCS 5/3 specifies the jurisdiction of the Auditor General and section 3-2 identifies the mandatory post audits. In conjunction with HFS' portion of the Statewide Single Audit, a sample of provider billings for Medicaid payments, that may include billings for Medicaid payments for waiver services, are reviewed. The Illinois Office of the Auditor General is responsible for conducting the financial audit program.

(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;

IDoA and HFS work cooperatively to review rates and provider claims. HFS implements procedures that provide assurance that claims will be coded and paid in accordance with the reimbursement methodology specified in the waiver.

IDoA also has mechanisms in place to ensure that provider agency and CCU billings are coded and reimbursed accurately. The process begins after the Level of Care (LOC) determination is completed. The CCU enters information collected from the assessment into CMIS, a relational computerized database. Numerous edits are performed in CMIS that will not allow a CCU to approve a participant to receive CCP services without eligibility criteria being complete and accurate. CMIS will not allow the CCU to process information when the participant's date of birth indicates the participant is under 60 years of age, and thus not eligible for services through the waiver. A participant cannot be authorized to receive services if the participant has not scored the minimum 29 points on the DON. Additionally, the CCU cannot authorize more CCP services than that allowed by the service maximum related to the DON score. The data

collected in CMIS creates a Case Authorization Transaction (CAT) that is transmitted to IDoA by the CCU.

Once the CAT is sent to IDoA, further edits of the data are performed. CATs can be rejected by IDoA's computer system for a multitude of reasons. The contract numbers for both the CCU and any provider agency authorized are checked against IDoA's file of contract information. If any of the contract numbers are incorrect or not valid for the time period, the CAT will be rejected. IDoA Information Technology and Business Services staff review and update the contract number tables frequently to assure the information is correct.

Edits are also performed based on the type of CAT assessment the CCU has generated. For example, certain information is required for data when the individual will be a CCP participant that is different than a CAT generated when an applicant was denied CCP services. This ensures that all information required to pay a CCP provider is accurate and complete.

Other edits that ensure appropriate billing is submitted by the provider agency include that the CCU cannot authorize CCP services prior to the application date, prior to the date the CCU determined the participant eligible for CCP, or prior to the initial service date of which the provider agency informs the CCU.

Once the CAT has been accepted in IDoA's system for a CCP participant, only the provider agency on the CAT will be authorized to bill beginning after the initial service date. Extensive edits are also conducted at the time of the provider agency's billing. An agency cannot bill for any services that were not authorized by the CCU on the CAT. For example, an ADS cannot bill for transportation if it was not authorized on the CAT; nor can the ADS bill for transportation in a month in which ADS services were not provided.

Provider agencies submit billing to IDoA by either uploading a file from their local computer or entering the data directly on the eCCPIS Internet web pages. If uploading a file from the computer, billing claims will reject for a number of reasons including: if the participant information is not in IDoA's system, the provider contract number is not accurate or current or for an invalid provider service code.

Another safeguard for all provider billings is that the payment will be rejected if the billing was previously submitted. Once a CCU bills for a particular assessment, that assessment will no longer appear as viable to be billed. Provider agencies cannot bill over the authorized number of units for a month of service. Additionally, if one provider agency has already billed for a given month and the participant has switched providers during that month, and the second provider agency attempts to bill for service that exceeds their portion of the month, the eCCPIS will verify that the second provider agency is authorized, and will also reject the billing if that agency bills more than is allowable based on the DON score and the billing by the first agency.

The Medicaid Agency has implemented oversight procedures that provide increased assurance that claims are coded and paid in accordance with the reimbursement methodology specified in the waiver. These processes enable staff to monitor the financial aspects of the waiver for Persons who are Elderly from a global perspective, rather than review a sample of paid claims. The Medicaid Agency determined that reviewing a sample of paid claims was of limited effectiveness and would not likely disclose problematic billings, patterns and/or trends.

The Medicaid Agency staff utilizes its Data Warehouse query capability to analyze the entire dataset of paid waiver claims. The Medicaid Agency utilizes an exception report and review format as a component of the agency's financial accountability activity. Agency staff have constructed database queries that encompass waiver eligibility, coding and payment criteria. Based on these criteria, twice a year the Medicaid Agency conducts analysis of all paid claims and only the claims that were not paid in accordance with set parameters are identified and extracted. The identified exceptions are printed out with all relevant service data. Current exception reports identify paid claims for waiver services to participants who were in a nursing home or who are deceased. In addition to the exception reviews of waiver claims, Medicaid Agency staff conduct targeted reviews of individual waiver services, utilization of waiver services by individual recipient and billing trends and patterns of providers. These reviews are usually conducted on an impromptu basis.

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

In addition to the HFS post-review and the IDoA edits described above, IDoA also has staff review Hours of Service Calendars (HOSCs) for a sample of participants during Quality Improvement reviews of ADS and homemaker provider agencies. HOSCs are checked for accuracy of completion including: signatures of the participant, worker, and supervisor and accurate total number of units. IDoA staff also compare the number of units on the HOSC to the amount of units billed by the provider agency for that month.

IDoA continuously implements enhancements to the eCCPIS in order to assist CCUs and provider agencies with billing processes. The IDoA seeks input from provider agencies, CCU users of eCCPIS and AAAs on functional improvements to the system. Several reports have been added to the eCCPIS as a result.
IDoA contracts with Shawnee Information Systems Development (SISD) to maintain and update CMIS and provide technical assistance to all CCU users. SISD conducts periodic trainings for CCU users on how to enter data and utilize reports available in CMIS.

c) The agencies responsible for conducting the financial audit program:

HFS, IDoA and the Auditor General are responsible for conducting the financial audit program.

For participants enrolled in an MCO, the Medical agency's internal and external auditing procedures will ensure that payments are made to a managed care entity only for eligible persons who have been properly enrolled in the waiver.

The Plans are responsible for reviewing payments made directly to providers for waiver services as part of the MCO contract. The Plans must have an internal process to validate payments to waiver providers. This includes the claims processing system verifying an individual's waiver eligibility prior to paying claims. This will be reviewed in the Readiness Review.

Post-payment plans of care and financial reviews are also conducted. Additionally, the Plans will implement 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 to validate they received services.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(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:
43I: Eligibility is verified and services are authorized prior to payments being made for services through the IDoA management information system.

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

eCCPIS

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

Data Aggregation and Analysis:

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

Performance Measure:

46I: The administrative claim costs for the operating agency are reviewed in compliance with the approved DoA Public Assistance Cost Allocation Plan.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Approved IDoA Public Assistance Cost Allocation Plan

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

Data Aggregation and Analysis:

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

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

Performance Measure:
44I: The IDoA management information system ensures that paid claims do not exceed the authorized limits on services for each individual.

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

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

Data Aggregation and Analysis:

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

☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
45I: 100% of waiver participants will be eligible and enrolled in the waiver on the date of service that waiver claims are paid.

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

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

HFS Data Warehouse Queries and Reports

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

Data Aggregation and Analysis:

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

Performance Measure:
47I: # and % of payments that were paid using the correct rate as specified in the waiver application. N: # of OA and MCO payments using the correct rate as

specified in the waiver application. D: Total # of OA and MCO payments.

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

Data Aggregation and Analysis:

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

Performance Measure:
48I: # and % of payments there were paid for services that were specified in the participant's service plan. N: # of payments made to the MCO that are specified in the participant's service plan. D: Total # of MCO payments.

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

Data Aggregation and Analysis:

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

☐ **Continuously and Ongoing**
☑ **Other** Specify: Semi-Annually

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.

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

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

For the administrative claims review, the MA reviews the entire DoA claim related to Medicaid administrative costs.

For the waiver claims review, the Medicaid Agency staff utilize the Data Warehouse query capability to analyze the entire dataset of paid waiver claims. The Medicaid Agency utilizes an exception report and review format as a component of the agency's financial accountability activity. Agency staff have constructed database queries that encompass waiver eligibility, coding and payment criteria. Based on these criteria, twice a year the Medicaid Agency conducts analysis of all paid claims and only the claims that were not paid in accordance with set parameters are identified and extracted. This review will include capitation payments made to MCOs and encounter claims submitted by MCOs.

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS' contracts with Integrated Care Program MCOs that provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc.
Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants enrolled in an MCO through consumer surveys and quarterly record reviews. Participants in MCOs are included in the representative sampling.

Additionally, the Plans will implement 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 to validate they received services.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.
43I:HFS will require the OA to void the federal claim for services provided prior to the customers' waiver enrollment. Remediation must be completed within 30 days.

44I:If claims are paid which exceed the authorized limits, the OA will initiate the claims adjustment within 60 days of discovery.

45I: HFS will require the OA to void the federal claim for services provided prior to the customers' waiver enrollment. Remediation must be completed within 30 days. HFS will adjust the federal claim for services provided by the MCO prior to the customers' waiver enrollment. Remediation must be completed within 30 days.

46I: If administrative claim costs are out of compliance with approved DHS Public Assistance Cost Allocation Plan, the OA will work with the MA to regain compliance. Remediation must be completed within 30 days.

47I:HFS will require the MCO to recoup the overpayment or repay at correct rate. Remediation must be completed within 30 days.

48I:The MCO will determine whether the service was authorized. If authorized, the MCO will revise customer service plan; If not authorized, the MA will void the federal claims that were not consistent with service plans. Remediation must be completed within 30 days.

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

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

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).

Rate methodologies are developed by the Community Care Program within the Operating Agency (OA) with consultation and final approval by the Medicaid agency (MA). All waiver rates must be reviewed and approved by the MA, and are subject to public comment. The MA solicits public comments when changes in methods and standards for establishing payment rates under the waiver are proposed. The notice is published in accordance with the Federal requirements in 42 CFR 447.205, which prescribes the content and publication criteria for the notice. Copies of the rate notices are on file with HFS. The rates are available to the public through the OA's website.

Rates of payment for program services since the initial 1915c waiver was approved have been established as described below:

In-home services: In-home services rates are fixed unit rates. To establish the initial rate in the original joint 1982 Aging and Disability waiver, IDoA employed an RFP process where applicants indicated their costs for providing the service and the size of the population each applicant projected it could serve. The rate was then established at one standard deviation above the mean of the weighted costs received. Subsequent rates added COLA to the previous rate or through rates agreed upon between the State and SEIU. Effective 07/01/08, a three-year agreement raised the in-home services rate to coincide with the three-step increase in the federal Fair Minimum Wage Act of 2007.

The in-home service rates include administrative costs and direct care staff wages. Rule, 89 Illinois Administrative Code, Part 240-Section 2040, provides that in-home services agencies must expend a minimum of 77% of the total revenues on the direct service worker. The rates are not geographically based and do not include room and board. Effective 07/01/08, the rate was enhanced to cover health insurance costs under PA 95-713. Total revenue does not include any amount received as an enhanced rate for health insurance costs by a provider.

In-home services rates are reviewed annually and adjustments are made to conform to the Community Care Program's (CCP) appropriation and to program service requirements and Federal and State changes in statutes and rules affecting the CCP. In establishing fixed unit rates of reimbursement, IDoA takes into consideration the following: 1) service utilization and cost information; 2) current market conditions and trend analyses; and 3) CCP budgetary cost assumptions and enacted appropriation. In-home services rates are formalized by the GA in IDoA's enabling legislation (20 ILCS 105/4.02).), and through the annual appropriations budget process.

Adult Care Day Service (ADS) rates are based on a fee-for-service reimbursement rate structure that consists of two fixed unit rates, one for ADS and another for transportation. The initial unit rate for ADS was established as five direct client contact hours per day (excluding transportation). In April 1996, IDoA changed the definition of an ADS unit to allow less than five hours of ADS to be authorized. The ADS rates include both administrative and direct care costs. They are not geographically based and do not include room and board.

The fixed unit rates are reviewed annually and adjustments are made to conform to the CCP appropriation and to program service requirements and Federal and State changes in statutes and rules affecting the CCP. In establishing fixed unit rates of reimbursement, IDoA takes into consideration the following: 1) service utilization and cost information; 2) current market conditions and trend analyses; and 3) CCP budgetary cost assumptions and enacted appropriation.

Subsequent rates are determined by adding negotiated COLA increases to the previous rates, which have been formalized by the General Assembly in IDoA's enabling legislation (20 ILCS 105/4.02).), and through the annual appropriations budget process.

Emergency Home Response (EHR) rates are based on fixed unit rates that were established in 2007, pursuant to an RFI process. Payment includes a one-time installation fee and a separate monthly rate for ongoing EHR services. The rate covers the following: maintaining adequate local staffing levels of personnel, installation, training, signal monitoring, technical support and repairs. Rates are not geographically based and do not include room and board. In establishing fixed unit rates of reimbursement, IDoA takes into consideration the following: 1) service utilization and cost information; 2) current market conditions and trend analyses; and 3) CCP budgetary cost assumptions and enacted appropriation.

The fixed unit rates are reviewed and adjustments are made when negotiated and approved as part of the annual CCP appropriation process; and to conform to applicable Federal and State changes in statutes and rules affecting the CCP.

Capitated rates for waiver services implemented through MCOs were developed by the State's contracted actuary by analyzing historical waiver data information including: enrollment, utilization and paid claims. This information was converted to a Per Participant Per Month (PPPM) basis and stratified by waiver service. The capitated rate for MCOs is a flat monthly rate, and is in compliance with 42 CFR 438.6.

Automated Medication Dispenser (AMD): The AMD fixed unit rates were established in 2013, pursuant to a Request for Information (RFI) process followed by establishing a rate methodology for an average fee-for service reimbursement rate to ensure adequate provider participation and participant choice. The payment consists of a one-time installation fee and separate monthly rate for ongoing rental and technical support of the AMD. The installation rate covers the following: maintaining adequate local staffing levels of qualified personnel to service necessary administrative activities, installation, and in-home training. The monthly rental rate covers the following: maintaining administrative and technical support to program machines, providing 24 hour technical assistance, signal monitoring, troubleshooting, providing machine maintenance and repair requests in a timely manner, sending notifications on missed doses and providing reports as requested by IDoA. Rates are not geographically based and do not include room and board. In establishing fixed unit rates of reimbursement, IDoA takes into consideration the following:
1) Cost information provided by service providers;
2) Current market conditions and trend analyses; and
3) Community Care Program budgetary cost assumptions and enacted appropriation.

The fixed unit rates are reviewed annually, at a minimum, and adjustments are made to conform to the Community Care Program's appropriation and to program service requirements and Federal and State changes in statutes and rules affecting the Community Care Program. The rates are available to the Public through the IDoA website at http://www.state.il.us/aging/.

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:

The CCUs enter information collected from the assessment into the CMIS, a relational computerized database. The data collected in CMIS creates a Case Authorization Transaction (CAT) that is transmitted to IDOA by the CCU via internet (eCCPIS). CAT information includes authorization for service by contract number, amount of authorized units, and initiation date for each authorized service. Provider agencies submit billing to IDoA by either uploading a file from their local computer or entering the data directly on the eCCPIS Internet web pages. IDoA verifies the provider billing against the CAT service record. The provider billing must pass through numerous edits before fiscal processing begins. Once the provider billing is approved, IDoA prepares a voucher for payment. IDoA then submits claims to HFS for Medicaid waiver claiming for all eligible participants.

Medicaid agency claims processing
IDoA waiver claiming data are transmitted to the Medicaid agency via computer tape exchange. The waiver subsection of the MMIS matches the individual against the recipient eligibility file to ensure Medicaid eligibility on the date of service and matches the provider against the provider enrollment file to ensure that the provider is enrolled as a waiver provider with the Medicaid agency. The waiver MMIS includes edits for waiver claims that conflict with other waivers, hospitals, nursing home, hospice facilities, or ICF/MR claims and rejects waiver claims that are duplicative or incompatible.

The Medicaid agency pays the Managed Care Organizations (Plans) a monthly capitated rate for waiver services.

This payment is generated from MMIS based on participants' eligibility in the database system for waiver services. Waiver providers receive payment for services by billing the Plans. The Plans issue payments based on claims received and verification of individual participant waiver eligibility. These claims paid by the MCO are then submitted through the State's MMIS system as encounter data.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Provider billings are validated by IDoA to verify the effective date of the participant's authorization for services as included in an approved plan of care. Paid Claims are passed through to HFS and MMIS processing edits are initiated for Medicaid and waiver eligibility. Lastly, HFS performs post-payment plan of care and financial reviews.

Monthly capitated rates are paid by the Medicaid Agency to the Managed Care Organizations (Plans). This payment is generated by the MMIS based on participants''eligibility for waiver services as identified in the database system. The Plans only receive payment for individuals eligible for waiver services. 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 MA 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, the MCOs are required to review their monthly payment and report to the Department any discrepancies.

In general, the rate cells for the Medicaid Component are stratified by age (21-64 and 65+), geographic service area (Greater Chicago and Central Illinois), and setting-of-care.
Capitation Rate updates will take place on January 1st of each calendar year. MCOs will be provided a rate report, to be signed by MA and MCO, on an annual basis for the upcoming calendar year.

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 then sent on to the 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. HFS then creates a HIPAA 820 files 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 will implement 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 to validate they received services.

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 the MCOs are required to review their monthly payment and report to the MA for discrepancies.

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:

IDoA makes payments from a central computer system and submits to the comptroller's office for payment. Claims are then sent to HFS for further editing and for Medicaid claiming. The audit trail is established through state agency approved rates, service plan authorizations, documentation of service delivery, and computerized payment and claiming systems cross-matched with the MMIS.

Monthly capitated rates are paid by the Medicaid Agency to the Managed Care Organizations (Plans). This payment is generated by the MMIS based on participants'eligibility for waiver services as identified in the database system. The Plans only receive payment for individuals eligible for waiver services.

- ○ **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.**
- [x] **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:

The limited fiscal agent is a function of the operating agency IDoA.

The provider signs the three-party Medicaid provider agreement that allows voluntary reassignment of pay. The operating agency makes payments directly to providers of waiver services and certifies those expenditures to the Medicaid agency.

The operating agency explains to providers that the waiver agreement voluntarily reassigns payment responsibility to the operating agency and that they have the option to bill HFS, directly, if they choose.

The Operating Agency passes the detail expenditure data once a month via an electronic tape to HFS, the Single Statewide Medicaid claiming agency for the State of Illinois. The data is fed into the Medical Management Information System (MMIS) and is subject to edits to ensure the information provided is accurate and that the services/providers are eligible for federal match under Title XIX. Should any claims have inaccurate information those claims are rejected by the system and a file of the rejected claims is passed back to the Operating agency for their review. Claims that pass through the system without error pass into the Management Administrative Reporting System (MARS) reporting unit. The MARS unit is responsible for generating the reports to the Bureau of Federal Finance (BFF) who use the reports to claim Medicaid expenditure data quarterly on the CMS 64. MARS also has a series of edits and codes that are used to filter data to ensure accuracy and to determine to what program the expenditure should be reported. The BFF reports the expenditures on the CMS 64 on a quarterly basis 30 days after the quarter's end.

In accordance with the Cash Management Improvement Act (CMIA), the BFF draws down federal monies from the Title XIX grant for the waiver on a weekly basis and deposits the funds into the General Revenue Fund (GRF). The amount to be drawn is an estimate derived by using historical expenditure data. Once the CMS 64 is completed at the quarter’s end, the BFF reconciles the estimated cash draw to the actual expenditures reported on the CMS 64. The reconciling expenditure amount is either added to or subtracted from the grant award depending on whether or not the adjustment is over or under the original estimated amount.

- [x] **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:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- ( ) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- (●) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

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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.** *Select one:*

- ○ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ○ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ◉ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

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:

The operating agency receives the non-federal share through the General Revenue Fund appropriations.

- ☐ **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:
Do not complete this item.

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	8565.70	3294.68	11860.38	28744.16	2208.99	30953.15	19092.77
2	8276.26	3522.74	11799.00	29981.97	2216.08	32198.05	20399.05
3	8341.15	3766.59	12107.74	31273.08	2223.19	33496.27	21388.53
4	8409.88	4027.32	12437.20	32619.79	2230.32	34850.11	22412.91
5	8484.47	4306.10	12790.57	34024.50	2237.47	36261.97	23471.40

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	**79090**	79090
Year 2	**92054**	92054
Year 3	**105618**	105618
Year 4	**122447**	122447
Year 5	**143101**	143101

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay is based on the last five 372 Reports.

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 for these estimates is as follows:

Estimates are based on an analysis of data for FY2010 through FY2014 (estimated) historical average percent

of change, comprised of rate increases and case mix changes of current utilization and costs among participants enrolled in the waiver. These estimates were subsequently projected forward using the same historical percentage of growth for the total unduplicated client count for fee-for-service and applied the same percent of growth to each individual waiver service.

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:

Fee-for-service Population:

We have assumed the cost per unit will remain the same. We have calculated the units per user by adjusting the aggregate number of units in both the fee-for-service and MCO populations. The Factor D' percentage is a 6.92% increase.

MCO Population:

We have distributed an average monthly capitation rate of $1,700 across the rate categories. We have assumed that the average length of stay on the waiver would be the same for both the fee-for-service and MCO populations. We have assumed that the average units per user would be consistent with the current Factor D. We have assumed the same ratio of users per service based on the current Factor D. The cost per unit of service was used as the residual calculation after determining the other variables.

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 is the institutional cost per person for those over 60 years. Factor G is estimated to increase by 4.30% each year for WY'10 - WY'14 due to utilization. The 4.30% increase incorporates both case mix increases and rate increases to Nursing Homes for each waiver year.

For participants receiving nursing facility services through a Managed Care Organization (MCO), a capitation rate specific to nursing facility services is used. The capitation rate was developed based on historical fee-for-service nursing facility costs from state fiscal years (SFY) 2008 through 2011. The historical nursing facility experience was trended forward to the contract rating years.

Since not all nursing facility residents are enrolled in an MCO, Factor G was developed based on a blend of those remaining in fee-for-service and those enrolling in an 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 Prime is estimated to decrease by .32% for the next five waiver years. This percentage is based upon the average historical percent change for WY'10 - WY'14 (estimated). Actual ancillary expenditures per capita for Institutional residents and carried forward to WY'14- WY'20. These estimates include case mix and rate increases. Factor G Prime is based on ancillary services received by the comparable population of nursing home residents over age 60.

The projections were based on utilization of Medicaid ancillary services for waiver participants and nursing facility participants. Waiver participants receive additional services that are covered by non-Medicaid funded entities. Examples include Title III services, home-delivered meals, and medication monitoring services provided through various demonstration projects. The combination of waiver services and other services, as described above may assist in lowering the need for the Medicaid ancillary services, thus resulting in D' projections being lower than G' projections.

The capitation rate nursing facility residents enrolled in Managed Care Organization 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 developed based on historical fee-for-service costs for ancillary services for nursing facility residents from state fiscal years 2010 through 2014. The historical ancillary service expenditures were trended forward to the contract rating years. The capitation rate also includes an administrative and risk load appropriate for the MCO.

Since not all nursing home residents are enrolled in an MCO, Factor G was developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Adult Day Service
In-home Service
Automated Medication Dispenser (AMD)
Emergency Home Response Service

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	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**18738452.14**
Adult Day Service	☐	Hour	2122	496.41	9.02	**9501505.82**	
Adult Day Service Capitated	☑	Hour	280	307.00	16.77	**1441549.20**	
Adult Day Service MMMAI	☑	Hour	279	515.00	10.63	**1527371.55**	
Adult Day Service MMAI Opt Out	☑	Hour	140	308.00	9.02	**388942.40**	
Adult Day Service Transportation	☐	Hour	3864	154.00	8.30	**4938964.80**	
Adult Day Service Transportation Capitated	☑	Hour	259	105.00	15.43	**419618.85**	
Adult Day Service Transportation MMAI	☑	Hour	258	163.00	9.78	**411288.12**	
Adult Day Service Transportation MMAI Opt Out	☑	Hour	129	102.00	8.30	**109211.40**	
In-home Service Total:							**652874405.47**

Homemaker	✓	Hour	69065	427.00	18.27	**538796093.85**	
Homemaker Capitated	✓	Hour	4634	378.00	33.97	**59503618.44**	
Homemaker MMAI	✓	Hour	4628	427.00	21.53	**42546638.68**	
Homemaker MMAI Opt Out	✓	Hour	2310	285.00	18.27	**12028054.50**	
Automated Medication Dispenser (AMD) Total:							**820.00**
Automated Medication Dispenser Service		Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Service Capitated	✓	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Service MMAI	✓	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Service MMAI Opt Out	✓	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Installation		One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation Capitated	✓	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation MMAI	✓	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation MMAI Opt Out	✓	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Service		Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service Capitated	✓	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service MMAI	✓	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service MMAI Opt Out	✓	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Installation		One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation Capitated	✓	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation MMAI	✓	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation MMAI Opt Out	✓	One-Time	1	1.00	50.00	**50.00**	
Emergency Home Response Service Total:							**5847473.83**
Emergency Home Response						**4973472.00**	

Service	☐	Month	22203	8.00	28.00		
Emergency Home Response Service Capitated	☑	Month	599	8.00	52.06	**249471.52**	
Emergency Home Response Service MMAI	☑	Month	1484	8.00	32.99	**391657.28**	
Emergency Home Response Service MMAI Opt Out	☑	Month	743	5.00	28.00	**104020.00**	
Emergency Home Response Service Install	☐	One-time	3551	1.00	30.00	**106530.00**	
Emergency Home Response Service Install Capitated	☑	One-time	186	1.00	55.78	**10375.08**	
Emergency Home Response Service Install MMAI	☑	One-time	237	1.00	35.35	**8377.95**	
Emergency Home Response Service Install MMAI Opt Out	☑	One-time	119	1.00	30.00	**3570.00**	

GRAND TOTAL:	**677461151.44**
Total: Services included in capitation:	657940473.82
Total: Services not included in capitation:	19520677.62
Total Estimated Unduplicated Participants:	**79090**
Factor D (Divide total by number of participants):	**8565.70**
Services included in capitation:	8318.88
Services not included in capitation:	246.82
Average Length of Stay on the Waiver:	266

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 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 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**29822369.14**
Adult Day Service	☐	Hour	4324	463.00	9.02	**18058148.24**	
Adult Day Service Capitated	☑	Hour	325	307.00	17.11	**1707150.25**	
Adult Day Service MMMAI	☑	Hour	628	515.00	10.84	**3505872.80**	
Adult Day Service MMAI Opt Out	☑	Hour	1	1.00	8.30	**8.30**	

Adult Day Service Transportation	☐	Hour	3998	154.00	8.30	**5110243.60**	
Adult Day Service Transportation Capitated	☑	Hour	300	105.00	15.74	**495810.00**	
Adult Day Service Transportation MMAI	☑	Hour	581	163.00	9.98	**945135.94**	
Adult Day Service Transportation MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
In-home Service Total:							**725558120.92**
Homemaker	☐	Hour	71461	427.00	18.27	**557487984.69**	
Homemaker Capitated	☑	Hour	5375	378.00	34.65	**70400137.50**	
Homemaker MMAI	☑	Hour	10416	427.00	21.96	**97669998.72**	
Homemaker MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
Automated Medication Dispenser (AMD) Total:							**615.04**
Automated Medication Dispenser Service	☐	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Service Capitated	☑	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Service MMAI	☑	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Service MMAI Opt Out	☑	Month	1	1.00	0.01	**0.01**	
Automated Medication Dispenser Installation	☐	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation Capitated	☑	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation MMAI	☑	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation MMAI Opt Out	☑	One-Time	1	1.00	0.01	**0.01**	
AMD & EHRS Service	☐	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service Capitated	☑	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service MMAI	☑	Month	1	1.00	65.00	**65.00**	
AMD & EHRS							

Service MMAI Opt Out	✓	Month	1	1.00	0.01	**0.01**	
AMD & EHRS Installation		One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation Capitated	✓	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation MMAI	✓	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation MMAI Opt Out	✓	One-Time	1	1.00	0.01	**0.01**	
Emergency Home Response Service Total:							**6482096.67**
Emergency Home Response Service		Month	22973	8.00	28.00	**5145952.00**	
Emergency Home Response Service Capitated	✓	Month	695	8.00	53.11	**295291.60**	
Emergency Home Response Service MMAI	✓	Month	3340	8.00	33.65	**899128.00**	
Emergency Home Response Service MMAI Opt Out	✓	Month	1	1.00	0.01	**0.01**	
Emergency Home Response Service Install		One-time	3674	1.00	30.00	**110220.00**	
Emergency Home Response Service Install Capitated	✓	One-time	216	1.00	56.90	**12290.40**	
Emergency Home Response Service Install MMAI	✓	One-time	533	1.00	36.05	**19214.65**	
Emergency Home Response Service Install MMAI Opt Out	✓	One-time	1	1.00	0.01	**0.01**	

GRAND TOTAL:	**761863201.77**
Total: Services included in capitation:	175950448.24
Total: Services not included in capitation:	585912753.53
Total Estimated Unduplicated Participants:	**92054**
Factor D (Divide total by number of participants):	**8276.26**
Services included in capitation:	1911.38
Services not included in capitation:	6364.88
Average Length of Stay on the Waiver:	266

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 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 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**34546854.60**
Adult Day Service	☐	Hour	4868	463.00	9.02	**20330033.68**	
Adult Day Service Capitated	☑	Hour	371	307.00	17.45	**1987502.65**	
Adult Day Service MMMAI	☑	Hour	816	515.00	11.06	**4647854.40**	
Adult Day Service MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
Adult Day Service Transportation	☐	Hour	4501	154.00	8.30	**5753178.20**	
Adult Day Service Transportation Capitated	☑	Hour	342	105.00	16.06	**576714.60**	
Adult Day Service Transportation MMAI	☑	Hour	755	163.00	10.17	**1251571.05**	
Adult Day Service Transportation MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
In-home Service Total:							**838935375.33**
Homemaker	☑	Hour	80444	427.00	18.27	**627566972.76**	
Homemaker Capitated	☐	Hour	6128	378.00	35.34	**81861010.56**	
Homemaker MMAI	☑	Hour	13540	427.00	22.40	**129507392.00**	
Homemaker MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
Automated Medication Dispenser (AMD) Total:							**820.00**
Automated Medication Dispenser Service	☐	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Service Capitated	☑	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Service MMAI	☑	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Service MMAI Opt Out	☑	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Installation	☐	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation Capitated	☑	One-Time	1	1.00	50.00	**50.00**	

Automated Medication Dispenser Installation MMAI	✓	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation MMAI Opt Out	✓	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Service		Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service Capitated	✓	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service MMAI	✓	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service MMAI Opt Out	✓	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Installation		One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation Capitated	✓	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation MMAI	✓	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation MMAI Opt Out	✓	One-Time	1	1.00	50.00	**50.00**	
Emergency Home Response Service Total:							**7492071.04**
Emergency Home Response Service		Month	25861	8.00	28.00	**5792864.00**	
Emergency Home Response Service Capitated	✓	Month	792	8.00	54.17	**343221.12**	
Emergency Home Response Service MMAI	✓	Month	4342	8.00	34.32	**1192139.52**	
Emergency Home Response Service MMAI Opt Out	✓	Month	1	1.00	0.01	**0.01**	
Emergency Home Response Service Install		One-time	4136	1.00	30.00	**124080.00**	
Emergency Home Response Service Install Capitated	✓	One-time	246	1.00	58.04	**14277.84**	
Emergency Home Response Service Install MMAI	✓	One-time	693	1.00	36.78	**25488.54**	
Emergency Home Response Service Install MMAI Opt Out	✓	One-time	1	1.00	0.01	**0.01**	

GRAND TOTAL:	**880975120.97**
Total: Services included in capitation:	767113749.53
Total: Services not included in capitation:	113861371.44
Total Estimated Unduplicated Participants:	**105618**
Factor D (Divide total by number of participants):	**8341.15**
Services included in capitation:	7263.10
Services not included in capitation:	1078.05
Average Length of Stay on the Waiver:	266

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 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 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**40468944.34**
Adult Day Service	☐	Hour	5536	463.00	9.02	**23119775.36**	
Adult Day Service Capitated	☑	Hour	423	307.00	17.80	**2311525.80**	
Adult Day Service MMMAI	☑	Hour	1061	515.00	11.28	**6163561.20**	
Adult Day Service MMAI Opt Out	☑	Hour	1	1.00	8.30	**8.30**	
Adult Day Service Transportation	☐	Hour	5118	154.00	8.30	**6541827.60**	
Adult Day Service Transportation Capitated	☑	Hour	390	105.00	16.38	**670761.00**	
Adult Day Service Transportation MMAI	☑	Hour	982	163.00	10.38	**1661485.08**	
Adult Day Service Transportation MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
In-home Service Total:							**980535958.64**
Homemaker	☐	Hour	91480	427.00	18.27	**713662009.20**	
Homemaker Capitated	☑	Hour	6986	378.00	36.05	**95197523.40**	
Homemaker MMAI	☑	Hour	17603	427.00	22.84	**171676426.04**	
Homemaker MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Automated Medication Dispenser (AMD) Total:							**820.00**
Automated Medication Dispenser Service	☐	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Service Capitated	☑	Month	1	1.00	40.00	**40.00**	
Automated Medication		Month				**40.00**	

Dispenser Service MMAI	✓		1	1.00	40.00		
Automated Medication Dispenser Service MMAI Opt Out	✓	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Installation		One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation Capitated	✓	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation MMAI	✓	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation MMAI Opt Out	✓	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Service		Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service Capitated	✓	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service MMAI	✓	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service MMAI Opt Out	✓	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Installation		One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation Capitated	✓	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation MMAI	✓	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation MMAI Opt Out	✓	One-Time	1	1.00	50.00	**50.00**	
Emergency Home Response Service Total:							**8759256.11**
Emergency Home Response Service		Month	29409	8.00	28.00	**6587616.00**	
Emergency Home Response Service Capitated	✓	Month	903	8.00	55.25	**399126.00**	
Emergency Home Response Service MMAI	✓	Month	5645	8.00	35.01	**1581051.60**	
Emergency Home Response Service MMAI Opt Out	✓	Month	0	0.00	0.01	**0.00**	
Emergency Home Response Service Install		One-time	4703	1.00	30.00	**141090.00**	
Emergency Home Response Service Install Capitated	✓	One-time	280	1.00	59.20	**16576.00**	
Emergency Home Response Service Install	✓	One-time	901	1.00	37.51	**33796.51**	

MMAI							
Emergency Home Response Service Install MMAI Opt Out	☑	One-time	0	0.00	0.01	**0.00**	

GRAND TOTAL:	**1029764979.09**
Total: Services included in capitation:	279712455.93
Total: Services not included in capitation:	750052523.16
Total Estimated Unduplicated Participants:	**122447**
Factor D (Divide total by number of participants):	**8409.88**
Services included in capitation:	2284.36
Services not included in capitation:	6125.53
Average Length of Stay on the Waiver:	266

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 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 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Service Total:							**47820634.92**
Adult Day Service	☐	Hour	6342	463.00	9.02	**26485840.92**	
Adult Day Service Capitated	☑	Hour	482	307.00	18.16	**2687207.84**	
Adult Day Service MMMAI	☑	Hour	1379	515.00	11.50	**8167127.50**	
Adult Day Service MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
Adult Day Service Transportation	☐	Hour	5864	154.00	8.30	**7495364.80**	
Adult Day Service Transportation Capitated	☑	Hour	445	105.00	16.71	**780774.75**	
Adult Day Service Transportation MMAI	☑	Hour	1277	163.00	10.59	**2204319.09**	
Adult Day Service Transportation MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
In-home Service Total:							**1155981516.70**
Homemaker	☐	Hour	104805	427.00	18.27	**817614198.45**	
Homemaker Capitated	☑	Hour	7964	378.00	36.77	**110692113.84**	

Homemaker MMAI	✓	Hour	22884	427.00	23.30	**227675204.40**	
Homemaker MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Automated Medication Dispenser (AMD) Total:							**820.00**
Automated Medication Dispenser Service		Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Service Capitated	✓	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Service MMAI	✓	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Service MMAI Opt Out	✓	Month	1	1.00	40.00	**40.00**	
Automated Medication Dispenser Installation		One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation Capitated	✓	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation MMAI	✓	One-Time	1	1.00	50.00	**50.00**	
Automated Medication Dispenser Installation MMAI Opt Out	✓	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Service		Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service Capitated	✓	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service MMAI	✓	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Service MMAI Opt Out	✓	Month	1	1.00	65.00	**65.00**	
AMD & EHRS Installation		One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation Capitated	✓	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation MMAI	✓	One-Time	1	1.00	50.00	**50.00**	
AMD & EHRS Installation MMAI Opt Out	✓	One-Time	1	1.00	50.00	**50.00**	
Emergency Home Response Service Total:							**10333211.06**
Emergency Home Response Service		Month	33693	8.00	28.00	**7547232.00**	
Emergency Home Response Service Capitated	✓	Month	1029	8.00	56.36	**463955.52**	

Emergency Home Response Service MMAI	✓	Month	7338	8.00	35.71	**2096319.84**	
Emergency Home Response Service MMAI Opt Out	✓	Month	1	1.00	0.01	**0.01**	
Emergency Home Response Service Install		One-Time	5388	1.00	30.00	**161640.00**	
Emergency Home Response Service Install Capitated	✓	One-Time	319	1.00	60.38	**19261.22**	
Emergency Home Response Service Install MMAI	✓	One-Time	1171	1.00	38.26	**44802.46**	
Emergency Home Response Service Install MMAI Opt Out	✓	One-time	1	1.00	0.01	**0.01**	

GRAND TOTAL:	**1214136182.68**
Total: Services included in capitation:	354831701.51
Total: Services not included in capitation:	859304481.17
Total Estimated Unduplicated Participants:	**143101**
Factor D (Divide total by number of participants):	**8484.47**
Services included in capitation:	2479.59
Services not included in capitation:	6004.88
Average Length of Stay on the Waiver:	266