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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
HCBS Waiver for Persons with HIV or AIDS

C. Waiver Number:IL.0202
Original Base Waiver Number: IL.0202.

D. Amendment Number:

E. Proposed Effective Date: (mm/dd/yy)
08/01/19
Approved Effective Date of Waiver being Amended: 10/01/18

2. Purpose(s) of Amendment

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

The purpose of this amendment is to seek federal approval of several service rate increases included in the State's Fiscal Year 2020 budget. Rates will be increased for the following services: Emergency Home Response Service Installation (EHRS), Adult Day Service (ADS) and Adult Day Service Transportation (ADST), and In-Home Services.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A Waiver Administration	

Component of the Approved Waiver and Operation	Subsection(s)
☐ Appendix B Participant Access and Eligibility	
☐ Appendix C Participant Services	
☐ Appendix D Participant Centered Service Planning and Delivery	
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☒ Appendix I Financial Accountability	
☒ Appendix J Cost-Neutrality Demonstration	

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

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

Specify:

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

1. Request Information (1 of 3)

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

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

HCBS Waiver for Persons with HIV or AIDS

C. Type of Request: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IL.0202
Draft ID: IL.011.06.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/18
Approved Effective Date of Waiver being Amended: 10/01/18

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:

Persons with HIV or AIDS

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

A 1915(b) waiver amendment was submitted on April 6, 2018 expanding the MLTSS program statewide. The amendment was approved on October 23, 2018 and is effective January 1, 2019 – December 31, 2019.

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

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

The Illinois' IL.13-015 1932(a) State plan amendment (SPA) to implement mandatory managed care for the adult aged, blind and disabled populations in Cook County and surrounding border counties was approved for the effective date of May 1, 2011.
The State enrolls Medicaid beneficiaries on a mandatory basis into managed care organizations (MCOs) through HealthChoice Illinois, which is a full-risk capitated program.
The SPA is operated under the authority granted by section 1932(a)(1)(A) of the Social Security Act. Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness, freedom of choice or comparability. The authority will not be used to mandate enrollment of Medicaid beneficiaries who are Medicare eligible, or who are Indians, except for voluntary enrollment as indicated in D.2.ii of the SPA.

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

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

☒ **A program authorized under §1115 of the Act.**

Specify the program:

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

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The HCBS waiver for Persons with HIV/AIDS was initially approved by CMS in 1990. This program is one of three home and community-based services (HCBS) waiver programs operated by the Department of Human Services, Division of Rehabilitation Services (DHS DRS). The Department of Healthcare and Family Services (HFS), as the single state Medicaid agency (MA), administers the waiver.

The MA and DRS, as the operating agency (OA), have entered into an interagency agreement that outlines the respective roles and responsibilities relative to all three DRS operated HCBS waiver programs. The interagency agreement is reviewed annually and updated as needed.

The purpose of the waiver is to serve persons with HIV/AIDS who are at risk for nursing facility level of care. The waiver allows individuals to remain in their homes and receive a wide-array of services.

The waiver is based on an independent living philosophy that encourages individuals to direct their own care. The most used service in the waiver is the personal assistant as it allows participants more privacy in directing their own care. If a waiver participant chooses this service, he or she may hire, train, and, if necessary, terminate the personal assistant or other individually hired provider such as a home health aide, licensed practical nurse, or registered nurse.

DHS DRS (OA) operates a payroll system for the independent providers that are hired by the waiver participants. Pay checks or direct deposits are processed every two weeks and the payroll system withholds unemployment, FICA, other employee benefits and other deductions as requested by the provider.

The OA Aids Administration Unit (AAU) within the OA performs the oversight functions. Certified AIDS case managers, located at 30 statewide case management offices, provide case management for HIV/AIDS waiver participants. Case managers are required to contact waiver participants at least once a month, with a face-to-face contact bi-monthly, to ensure the participant's needs are being met; services are provided in accordance with service plan; to monitor the participant’s health, safety and welfare; to follow-up on any identified issues; and to determine whether additional services are needed. In areas where HIV/AIDS case management offices are not established, waiver participants access and receive waiver program services through case managers employed through local OA offices. The case managers are the first-line of contact for waiver participants and families. In addition to monitoring service delivery, and participant health and welfare, the case management duties include conducting assessments for eligibility and, for those funded by the OA, developing and overseeing the service plan, connecting participants with providers, and explaining rights and responsibilities.

As of January 1, 2019, Illinois' mandatory managed care program, now called HealthChoice Illinois, will operate statewide offering providers the opportunity to contract managed care plans in all Illinois counties; numerous managed care plans will be available in Cook County. The Integrated Care Program (ICP), Family Health Plan/ACA Adults (FHP/ACA) and Managed Care Long Term Services and Supports (MLTSS) managed care programs are now incorporated in HealthChoice Illinois. Members enrolled in the Medicare Medicaid Alignment Initiative (MMAI) will not be impacted HealthChoice Illinois. Illinois received approval from the federal Centers for Medicare and Medicaid Services (CMS) to jointly implement the MMAI program on February 22, 2013. Section 1915(c) waivers impacted by MMAI were amended at that time.

Individuals who are transitioned into managed care services can access the same level of waiver services as provided by the OA through fee-for-service. Care coordinators for Managed Care Organizations are required to implement the same program guidelines as by OA counselors and case managers as indicated above.

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:

Public notice information for the transition to mandatory statewide managed care is located in Main - B. Optional due to character count limitations in this section. This public notice was posted for 30 days beginning April 2, 2018 in accordance with CMS regulations.
Tribal Notice was initiated on Monday, April 2, 2018 and continued until June 1, 2018. Tribal notice for the State of Illinois consists of notifying the American Indian Health Services of Chicago.

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: Cunningham

First Name: Kelly

Title: Deputy Medicaid Administrator, Long Term Care and Behavioral Health

Agency: Department of Healthcare and Family Services

Address: 201 South Grand Avenue East

Address 2:

City: Springfield

State: **Illinois**

Zip: 62763

Phone: (217) 782-2570 **Ext:** ☐ **TTY**

Fax: (217) 782-5672

E-mail: kelly.cunningham@illinois.gov

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

Last Name: Vandeventer

First Name: Lyle

Title: Waiver Specialist, Home Services Program

Agency: Department of Human Services, Division of Rehabilitation Services

Address: 100 S Grand Avenue East, 1st Floor

Address 2:

City: Springfield

State: **Illinois**

Zip: 62762

Phone: (217) 558-4142 **Ext:** ☒ **TTY**

Fax: (217) 557-0142

E-mail: Lyle.Vandeventer@Illinois.gov

8. Authorizing Signature

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

Signature:

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: Elwell

First Name: Douglas

Title:

Medicaid Director

Agency:

Healthcare and Family Services

Address:

201 South Grand Avenue East

Address 2:

City:

Springfield

State: **Illinois**

Zip:

62763

Phone:

(217) 782-2570 **Ext:** ☐ **TTY**

Fax:

(217) 782-5672

E-mail:

Doug.Elwell@Illinois.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

As a condition of approval for the HIV/AIDs waiver (effective date of September 20, 2017), it was determined that a CAP should be implemented for Administrative Authority and Health and Welfare. The CAP was approved 12/06/2017 and expected to be fully implemented by 6/30/2019.

The MCOs have full care management and full functioning systems currently in place to handle care management for the HIV/AIDS population. The MCOs have been coordinating care for this population in certain counties in Illinois since February 2013, and in this renewal, the State will expand this care management function to cover enrollees on the HIV/AIDS waiver statewide. This is not so much a transition as an expansion of the care management.

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The following is a continuation of Appendix I-2a :
Emergency Home Response rates are based on the rates established by IDoA in the Elderly Waiver (0143). EHR rates include a one-time installation fee and a separate monthly rate for ongoing EHR services. The rate covers maintaining adequate local staffing levels of personnel, installation, training, signal monitoring, and technical support and repairs.
EHR rates are based on fixed unit rates that were established in 2007, pursuant to a January 2006 Request for Information (RFI) process. Under this process, the Department on Aging solicited input from EHR providers regarding the services they could provide and their costs for doing so. Providers supplied quotes that covered costs associated with installation, monthly service rates and removal fees, any special pricing arrangements that could be offered (e.g. volume discount, reduced rates based on need, and a description of any region-specific packages/units that could be offered at a discount). Thirteen vendors responded to the RFI with similar products and services. With the highest and lowest quotes disregarded as outliers, the average quotes for installation and monthly monitoring were $31.25 and $38.40, respectively. Multiple providers also noted that their rates were negotiable or that they could match competitors' rates, and some offered discounts for second users. For monthly monitoring, the lowest quoted rate (after disregarding the outlier) was $28.00. Based on these factors, the IDoA chose, and HFS approved, the current rates of $30.00 for installation and $28.00 for monthly monitoring. Based upon a recent rate study completed by IDOA, it was recommended that the EHR installation rate should be increased as indicated below:
EHR Installation: $40.00
Rates are not geographically based and do not include room and board. EHR rates are reviewed annually to ensure budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program.
Home Delivered Meals: The home-delivered meals rates are standardized and are based on rates set under Title III of the Older Americans Act. The administrative rule specifies that the cost of HDM can be no more than what it would cost for a personal assistant to prepare the meal. The rates are not geographically-based and do not include direct or indirect administrative costs. The rate is subject to COLA when enacted and published on the OA's website under HSP. The current rate for home delivered meals is $15.00 per day.
Respite service rates methodologies are based on the established rate for each included service provider type. Rates are published on the OA's website under HSP.
Environmental Accessibility Adaptations & Specialized Medical Equipment and Supplies: Payments are subject to prior approval by the OA. For any item costing more than $1500, three bids are required and the lowest bidder is selected. If the lowest bidder cannot provide timely services, the next lowest bid may be selected. If three bids cannot be obtained or a bid is the sole source for lack of available vendors, a formal justification as to why three bids were not secured is required. Rate maximums, above which supervisory approval and written justification is required, are published on the OA's website under HSP.

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:

The Illinois Department of Human Services, Division of Rehabilitation Services (DHS-DRS), the operating agency (OA)

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:

The MA and OA have entered into an interagency agreement designating the roles and responsibilities of each entity. The interagency agreement is reviewed by the MA and OA at least annually.

The OA is responsible for the day-to-day operations and has budget appropriation for the OA Home Services Program (HSP), and therefore the waiver participants served under the HSP.
The OA is responsible for waiver participant eligibility, enrolling service providers and qualifying providers by assuring they meet standards established in the approved waiver and governing rules. The OA submits proposed policy changes affecting waiver participants to the MA for approval prior to implementation. For those waiver participants served under the OA HSP, the OA is responsible for service plan development, assuring that service plans are implemented and that services meet waiver standards.

The MA maintains administrative oversight of the waiver. The MA enrolls providers in Medicaid, processes federal claims, maintains an appeal process, provides consultation and conducts program and fiscal monitoring. The MA Medical Policy Review Committee reviews all rule and policy changes impacting the waiver. In addition, the MA conducts both program and fiscal monitoring. The MA and OA meet quarterly to discuss the overall administration of the waiver, remediation of findings and quality improvement strategies.

The MA program monitoring includes review of a random sample of participant's records, participant interviews and provider reviews. The MA annually conducts random, representative record reviews statewide. These are conducted onsite at the OA case management offices. The MA also annually conducts four comprehensive onsite provider reviews at case management offices. The MA record reviews are included as part of the OA's representative sample.

The record reviews monitor initial and ongoing eligibility, service plan development, participant's choice between waiver services and institutional care, and personal assistant provider qualifications. Comprehensive provider reviews are more extensive and include participant, case management and agency provider interviews; verifying compliance with rules and policies governing the programs; staff qualifications and training; quality assurance processes; and handling of complaints. Participant interviews evaluate health and safety, participant satisfaction, whether participants are active in the development of the service plan, and are informed of rights and choice.

As part of the comprehensive provider review, the MA reviews agency service providers, typically an In-home Service (homemaker) agency or Adult Day Care, when agency services are part of a participant's service plan. These reviews include verification of staff qualifications and training requirements.

In addition to the waiver program monitoring, the MA conducts fiscal monitoring. Findings are shared with the OA and remediation is tracked through closure.

OA is not involved in oversight and monitoring of MCO/Health Plan/Plans, only the MA. 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 Home and Community Based Services (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 the MMSE/DON completed by the Operating Agency (OA).

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.
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. 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.:*

Case management services for the waiver for persons with HIV/AIDs are performed by agencies under rate agreements with the operating agency, Department of Human Service, Division of Rehabilitation Services (DHS-DRS). The AIDS case managers provide the following functions as defined in 89 Il. Admin. Code 686.910:

1)Conducting the initial assessment of eligibility and information gathering;
2)Developing and monitoring the implementation of a care plan;
3)Conducting a reassessment of level of care at least every 12 months for those cases in formal eligibility, three months for those cases that have been presumptively determined eligible for interim services (89 Ill. Adm. Code 684.80), or at such time when the customer's financial or physical condition or need for services changes;
4)Networking, coordination and brokering of services (i.e., referring and assisting the customer in obtaining other agencies' services);
5)Assisting the customer when personal assistance problems develop. Maintaining documentation these problems and the case management team's responses in the customer's case file;
6)Providing counseling and advocacy;
7)Acting as inter-agency liaison (e.g., with other DHS programs, vendors, hospitals);
8)Contacting customer a minimum of once per month by telephone with a face-to-face visit every other month
9)Maintaining and updating customer records; and
10)Monitoring the cost effectiveness of the service plan.

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

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

In the MA's contracts with Integrated Care Program 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. As part of the MA's quality oversight and monitoring of the waiver providers, the EQRO will perform quarterly onsite audits of the enrollee care plans through chart validation; this will be submitted to the MA for review and analysis. 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. 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

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 Quality Improvement Strategies (QIS) will be reviewed and modified to assure that the Plans are complying with the federal assurances and performance measures that fall under the functions delegated to them by the MA. The waiver participants enrolled in an MCO will be included in the representative sample. The MA will monitor performance of the Plans through receipt and analysis of reported data, onsite visits, desk audits and interviews. The Plans will submit performance data at least quarterly, and more often as indicated by the contract. The MA will schedule onsite reviews and desk audits throughout the waiver year for the representative sample and validation reviews. The MA will meet quarterly with the Plans to identify and analyze trends based on scope, severity, changes and opportunities for system improvement.

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 will 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 will provide an Enrollee specific summary of findings by measure and a plan and Waiver specific summary report of findings and recommendations as appropriate. The report will include: Summary of non-compliance related to specific performance measures; Overall summary of record review findings; and Recommendations for remediation of non-compliance.

Appendix A: Waiver Administration and Operation

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

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

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
5A: # and % of individual findings regarding provider qualifications non-compliance that were remediated within 60 days by the OA and MCO. N: # of individual findings regarding provider qualifications non-compliance that were remediated within 60 days by the OA and 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; Provider Qualification 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:
Reports to MA on Delegated Certification/Training Report; HSP Provider Compliance 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: MCO	☒ **Annually**

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

Performance Measure:
14A: # 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:
6A: # and % of individ findings of non-compliance re: waiver prvdrs w/out a Medicaid Prvdr Agreement (MPA) on file at the MA that were remediated within 30 days by the OA and MCO. N:# of findings of non-compliance re: waiver prvdrs w/out a MPA on file at the MA that were remediated within 30 days by the OA and MCO. D:Total # of findings of non-compliance re: waiver prvdrs w/out a MPA on file.

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

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

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

Data 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:	☒ **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:
9A: # and % of service plans that were implemented prior to authorization by the OA and MCO with remediation within 60 days. N: # of service plans that were implemented prior to authorization by the OA and MCO with remediation within 60 days. D: Total # of service plans reviewed by the OA and 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 Source (Select one):
Other
If 'Other' is selected, specify:
Reports to MA on Delegated DHS Appeals Process; HSP QA Audit 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: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

7A: # and % of rate methodology changes submitted by the OA that are approved by the

MA and submitted for Public Notice prior to implementation. N: # of rate methodology changes submitted by the OA that are approved by the MA and submitted for Public Notice prior to implementation. D: Total# of rate methodology changes implemented.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Log of Rate Change Request

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

Data Aggregation and Analysis:

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

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

Performance Measure:
2A:# and % fiscal estimates where waiver enrollment slots,utilization and expenditures are less than or equal to the OA estimated levels in the approved waiver. N:# fiscal estimates of waiver enrollment slots, utilization and expenditures that are less than or equal to OA estimated levels in the approved waiver. D:Total# of fiscal estimates of waiver enrollment slots, utilization and expenditures.

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

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Semi-Annually	

Data Aggregation and Analysis:

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

Performance Measure:
4A: # and % of overdue Individual Service Plan 12 month renewals that were remediated within 30 days by the OA and MCO. N:# of overdue Individual Service Plan 12 month renewals which were remediated within 30 days by the OA and MCO. D: Total # of OA and MCO overdue Individual Service Plan 12 month 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 Source (Select one):
Other
If 'Other' is selected, specify:
Reports to MA on Delegated Need/Task Report (VCM) HSP QA Audit 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: MCO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
11A: # and % of required MCO reports submitted according to contract requirements. N: # of MCO required reports submitted according to contract requirements. D: Total # of MCO required reports.

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

Data Aggregation and Analysis:

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

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

Performance Measure:
3A: # and % individual findings of deficiencies regarding LOC reevaluations that were remediated by the OA within 60 days. N: # individual findings of deficiencies regarding LOC reevaluations that were remediated by the OA within 60 days. D: Total # of findings of deficiencies regarding LOC reevaluations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports to MA on Delegated Eligibility Report (VCM; HSP QA Audit Reports

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

Data Aggregation and Analysis:

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

Performance Measure:
13A: # and % of PIPs implemented in accordance with timeline in contract requirements. N: # of PIPs implemented in accordance with timeline in contract requirements. D: Total # of PIPs required by contract.

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:	☒ **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:
1A:# and % findings of non-compliance in the areas of pre-admission screening and waiver enrollment with evidence of remediation by OA within 60 days. N: # findings of non-compliance in the areas of pre-admission screening and waiver enrollment with evidence of

remediation by the OA within 60 days. D: Total # of findings of non-compliance in the areas of pre-admisn screening and waiver enrollment.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA reports: Reports to MA on Delegated Preadmission Screen Report (STARS); Waiver Enrollment Report (VCM)

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

Data Aggregation and Analysis:

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

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

Performance Measure:
8A: # and % of waiver program policies submitted to the MA prior to OA dissemination and implementation. N: # of waiver program policies submitted to the MA prior to OA dissemination and implementation. D: Total # of waiver program policies disseminated and implemented by the OA.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
12A: # and % of waiver participants provided choice by the enrollment broker when determining MCO plan selection. N: # of MCO plan waiver participants provided choice by the enrollment broker when determining MCO plan selection. D: Total # of MCO plan waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MA Enrollment Confirmation 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:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
10A: # and % of participant reviews conducted by the OA according to the sampling methodology specified in the waiver. N: # of participant reviews conducted by the OA according to the sampling methodology specified in the waiver. D: Total # of participant reviews by the OA required according to the sampling methodology.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports to MA on Delegated Reporting will be maintained as approved in 2012 waiver

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:
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:	☒ **Annually**

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

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

The Medicaid agency, MA, will conduct routine programmatic and fiscal monitoring for both the OA and the MCOs. The State does not change rates unless approved by CMS or through a General Assembly Action.

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 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.

In the MA's contracts with Integrated Care Program 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.

As part of the MA's quality oversight and monitoring of the waiver providers, the EQRO will perform quarterly onsite audits of the enrollee care plans through chart validation. This information will be submitted to the MA for review and analysis.

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.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

-
1A:Findings are corrected timely by the OA. If remediation not completed within 60 days, the OA reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

2A:The OA conducts an analysis of previous enrollment, utilization, and expenditure estimates. Estimates are revised as necessary and submitted to the MA for approval. If necessary, an amendment to the waiver is submitted to CMS.

3A:Findings are corrected timely by the OA. If remediation not completed within 60 days, the OA reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

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

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

6A:The OA will obtain Medicaid provider agreements The MCO will work with providers and the OA to obtain Medicaid provider agreements. If not qualified, the provider is dis-enrolled and the OA/MCO provides participant with other available providers. The OA/MCO trains case managers, if needed. If remediation not completed within 60 days, the OA/MCO reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

7A:The OA submits outstanding rate methodology changes to the MA for approval. If remediation is not within 30 days, the OA reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

8A:The OA submits outstanding policies to the MA for approval. If remediation is not within 30 days, the OA reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

9A:The OA/MCO provides training to case managers and authorizes service plans if appropriate. If remediation not completed within 60 days, the OA/MCO reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

10A:The OA/EQRO completes all outstanding case reviews, and reviews the case review scheduling/process to determine reasons for reviews not being conducted. If remediation not within 90 days, the OA/EQRO reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

11A:MA will require completion of overdue reports. The MCO will submit a plan of correction within 30 days.

12A:The enrollment broker will submit a plan of correction to the MA within 30 days. MA will provide training to the enrollment broker to ensure waiver participants are offered choice of MCO plans. Remediation must be completed within 60 days.

13A:The MCO will complete PIP in accordance with contract requirements. Remediation must be completed within 60 days. If not remediated within 60 days, the MA has the option to implement sanctions.

14A: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 for MCO case managers. Remediation 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
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☒	HIV/AIDS	0		☒
	☐	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:

Medical determination of HIV or AIDS with severe functional limitations, which are expected to last at least 12 months or for the duration of life.

Other Criteria include:

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 29 points on the DON.
4.Enrolled in one waiver, the waiver that most appropriately meets his or her needs.
5. Ability to be maintained safely in the home at a cost which does not exceed that of nursing facility care 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:

Appendix B: Participant Access and Eligibility

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

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and

community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

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

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

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

    Specify the percentage:

  - ○ **Other**

    Specify:

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

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

The University of Illinois-Chicago conducted a study to review the Determination of Need (DON)assessment tool to determine validity and possible need for revision. The study 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 (DoA). The tool was developed for two purposes: 1) as a prescreening tool for HCBS waivers operated by DHS-DRS, DoA and nursing facilities and 2) as a tool to assess level of services in these HCBS waivers and to identify service cost maximums, based on the case-mix strata.

To validate, the DON was administered to participants across the waiver programs operated by DRS and DoA. Based upon extensive data analysis, it was determined that the DON was a valid assessment tool, which adequately assessed level of impairment and need for services. A minimum score of 29 was identified for eligibility to a nursing facility and the waiver program. The maximum score is 100.

Analyses also identified ranges of DON scores and associated Service Cost Maximum (SCM) levels. These ranges were reflective of the severity of impairment and the participants' unmet needs. The level of funding required was then determined for each range of DON score, again depending upon level of impairment and need for service, similar to the case mix system in nursing facilities. Respective SCM were correlated with similar expenditures at or below those for nursing home placement and assigned by scoring ranges. The Managed Care plans are provided information and training on the DoN scores and how they corrrelate with the SCM levels. The DoN scores and SCMs are determined by the OA and shared with the Plans, initially, annually, and if there is a significant change.

If an individual does not meet eligibility requirements as outlined in the 89 Illinois Administrative Code, Section 682, the OA sends the individual a Service 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 request a hearing. The notice explains how to appeal with the appropriate forms enclosed. The Rights and Responsibilities document explains that all services which were 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.

Presently, Section 682.100 (g) requires a physician's certification at least every two years that "indicates the individual is in need of long-term care and this care can safely and adequately be provided in the individual's home according to the physician and the HSP Service Plan". The OA is preparing an emergency rule to file with Illinois' Joint Committee on Administrative Rules (JCAR) to eliminate this requirement. An emergency rule is in effect for 150 days, so a proposed rule to make the change permanent will be filed at the same time; it will go through JCAR's standard process for this type of rulemaking. More info about Illinois' Rulemaking Process can be found at http://www.ilga.gov/commission/jcar/ILRulemakingProcess.pdf.

The MA will notify CMS as soon as the emergency rule has been filed.

A waiver participant may appeal their DON score, if they choose. When an AIDS case manager makes an adverse case decision, the participant will receive a service notice that explains the decision and informs the participant of his/her right to appeal. The service notice is sent to the participant at least 15 days prior to the effective date of the action. The case manager is responsible to notify the participant immediately after the decision. If the participant desires assistance during the hearing, he/she may request such assistance from the DHS Client Assistance Program (CAP). Personnel within the CAP program are impartial advocates who assist the participant during the appeal process. The service notice indicates that services will continue until after the hearing office renders a decision. A copy of the service notice is retained in the case file. When available, a copy of the request for appeal may also be in the service file, and will always be maintained in the appeal file under the DHS Division of Hearings and Appeals. More information may be found in Appendix F-1 of the waiver application.

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:

Below are Determination of Need scores and associated Service Cost Maximums (SCM) for fiscal year 2019. SCMs may be updated in the future, based on increases in provider rates or other factors that impact the cost of waiver services.

Monthly Service Cost Maximum for 2019

DON Score	SCM
29-32	2,165
33-40	2,391
41-49	2,668
50-59	3,197
60-69	3,757
70-79	4,061
80-100	4,365

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:

-
Individual cost limits, referred to as the service cost maximum (SCM), correspond with scores on the Determination of Need (DON). Eligibility is determined by at least a minimal total score of 29 on the DON, with at least 15 points based on functional impairment. The range of scores and corresponding SCM is indicated under B-2 a. This amount directly corresponds to the amount the State would expect to pay for the nursing care component of institutionalization if the individual chose institutionalization.

The ranges were determined via research that was conducted by the University of Illinois Chicago, Gerontology Department. The purpose of the study was to verify that the DON scoring corresponded with impairment and need. The SCMs were developed by determining institutional costs incurred by individuals with similar DON scores. The cost of home and community-based services may not exceed the cost of institutionalization.

The participant must agree that the services will safely and adequately meet his or her needs, and signify this by signing the service plan. No plan may be implemented unless approved by the participant or guardian.

Expenditures are monitored on a monthly basis to ensure that annual expenditures will not exceed annual SCM. If customer’s needs are at a level where annual SCM will be exceeded, a reassessment is completed so that the customer’s needs will be appropriately scored on the Determination of Need, moving the SCM to the next appropriate level. This would raise the SCM to a level that would not be exceeded.

The OA filed the request with JCAR on July 25, 2014 to remove the physician's certification at least every two years. This information can be found at the following link:
http://www.ilga.gov/commissioni/jcar/admincode/089/089006840000750R.html
-

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

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

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

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

The Service Cost Maximum (SCM) for an individual may be exceeded on a monthly basis to meet a temporary increase in need for services as long as the average monthly cost for services during the twelve month period does not exceed the SCM. Such an increase in services shall not last more than three months.

If an individual does not meet eligibility requirements as outlined in the 89 Illinois Administrative Code, Section 682, DRS sends the individual a Service 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 request a hearing. The notice explains how to appeal with the appropriate forms enclosed. The Rights and Responsibilities document explains that all services which were in effect at the time of the appeal will continue until the decision of the appeal is issued. Previously, there was a requirement for physician's approval. As explained in more detail in Appendix B-2-b, the OA is working to eliminate the physician certification requirement in Section 682.100(g).

In addition to the Determination of Need assessment (DON), the case managers conduct more a comprehensive needs assessment that addresses multiple areas of needs, including non-waiver services. The OA case manager completes a narrative statement about the participant that accompanies this assessment. Case managers utilize various community resources to assist the waiver participants to access services when needed that are not covered under the waiver.

The SCM for HIV/AIDS waiver was established higher to address the need for therapy and other HIV/AIDS supportive services. If an individual has complex medical needs that cannot be served within the allowable SCM, the case manager may request an exceptional care (EC) rate. The EC rate is determined by the MA and based on higher rates paid in nursing facilities that serve medically complex residents or deliver special rehabilitative services, similar to that of the waiver participant. If the established SCM for a case is exceeded due to an approved provider rate increase, the participant may continue to receive the same amount of services even though the SCM will be exceeded.

Customers may experience a number of significant changes during the course of a year including loss of non-paid caregivers, increase in severity of disabling condition, change in living situations, etc. Customers are instructed to notify the OA when such a change occurs, and if necessary a reassessment will be completed.

If it is discovered that the customer’s needs have increased during the reassessment, this information is factored into the scoring of the Determination of Need, subsequently moving the SCM to the next appropriate level. Services will be modified in order to meet the customer’s needs.

The OA provides guidance during training to OA staff and MCO staff initially and annually. Determinations are based on interaction and communication between the case manager and the customer. With monthly contacts, changes are identified as soon as the need arises.

During training the OA provided guidance to the MCOs regarding the establishment of the SCM for waiver participants. The SCM is linked directly to the DON score. The MCOs are provided the DON scores and the SCMs for the specific DON scores.

-

☐ **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	1480
Year 2	1528
Year 3	1576
Year 4	1624
Year 5	1672

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. 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 will remain the same as for all participants. Initial waiver eligibility will be conducted by State-contracted case managers as specified in the existing waiver and be based on the same objective criteria as for all. Selection of entrants does not violate the requirement that otherwise eligible individuals have comparable access to all services offered in the waiver.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

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

- (●) **No**
- ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under

the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

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

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

  Select one:

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

  Specify percentage:

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

  Specify:

The state proposes to add:
1) Adults age 19 and above without dependent children and with income at or below 138% of the Federal Poverty Level (Adult ACA Population) as provided in Section 1902(a)(10)(A)(i)(VIII)of the Social Security Act (the Act) and Section 42 CFR 435.119 of the federal regulations.
2) Former Foster Care group defined as: young adults who on their 18th birthday were in the foster care system and are applying for Medical benefits and are eligible for services regardless of income and assets pertaining to Title IV-E children under Section 1902(a)(10)(A)(i)(IX)of the Act and Section 42 CFR 435.150 of the federal regulations.
3) Caretaker relatives specified at 42 CFR 435.110.
4) Children specified at 42 CFR 435.118.
5) Pregnant women specified at 42 CFR 435.116.

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

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

  Select one and complete Appendix B-5.

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

Check each that applies:

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

  Select one:

  - ○ **300% of the SSI Federal Benefit Rate (FBR)**
  - ○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

    Specify percentage: ☐
  - ○ **A dollar amount which is lower than 300%.**

    Specify dollar amount: ☐
- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- ☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- ☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- ☐ **Aged and disabled individuals who have income at:**

  Select one:

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

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

  Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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 submit Appendix B-5 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.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

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-4 indicate that you do not need to submit Appendix B-5 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 submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

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

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

- ( ) **Other**

Specify:

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

-
Persons performing level of care evaluations must be: a registered nurse with a current license and a Bachelor's Degree in nursing, social work, social sciences, or counseling, or four years of case management experience; or a social worker with a Bachelor's degree in social work, social sciences or counseling; a Bachelor's of Social Work or a Master's of Social Work from a school accredited by any organization nationally recognized for the accreditation of schools of social work is preferred; or an individual with a Bachelor's Degree in a human services field with a minimum of five years of case management experience. To assure continuity of care, the OA initially grandfathered case managers that maintained training requirements (even though they did not meet the educational requirements) if employed prior to July 1, 2005. There are currently only three case managers without degrees. All others have the required degrees and experience. All have been trained by the AIDS Administrative Unit (AAU), and are certified or in the process of certification.

All case managers for the HIV/AIDS waiver are required to attend an initial training by the OA. The AIDS Administrative Unit program manager assures that all new case managers meet the requirements.
-

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.

-
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 examination (MMSE) and functional status 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. Case managers 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. State rules regarding prescreening are found in 89 Il. Admin Code, Part 681. State rules pertaining to the DON are found in 89 Il. Admin Code, part 679.
-

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 AIDS case management entities, under rate agreements with the OA, conduct the level of care evaluations and reevaluations utilizing the Determination of Need and the same processes as described above.

For participants enrolled in an MCO, the reevaluations are conducted by the OA as described in the existing waiver.

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):*

The OA has the ability to run monthly reports through a Virtual Case Management computer system that does two things 1)creates a "To Do" list that gives case managers a 30-day advance notice of upcoming reassessments and 2) identifies case managers that are not completing redeterminations within the required timeframes. A post-review is also completed during monitoring visits conducted by both the OA and MA.

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 OA AAU case management agencies maintain evaluations and reevaluations. The OA Virtual Case Management system also maintains the evaluations and re-evaluations electronically for all participants, including those enrolled in an MCO.

The record retention requirements will be the same for MCO 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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
15B:# and % of new waiver participants who had a level of care assessment indicating need for NF level of care prior to receipt of services. N: # of new waiver participants who had a level of care assessment indicating need for NF level of care prior to receipt of services. D: Total # of new waiver participants receiving services.

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

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:
16B: # and % of waiver participants reassessed through the redetermination process of waiver eligibility every 12 months. N: # of participants reviewed where the participant was reassessed through the redetermination process every 12 months. D: Total # of waiver participants reviewed who had reassessment due.

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
17B: # and % of participants where documentation supports LOC determination. N: # of waiver participants where documentation supports the LOC determination. D: Total # of waiver participants reviewed who had an assessment/reassessment completed.

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

OA Reports: HSP QA Audit 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:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
18B: # and % of LOC determinations made by a qualified evaluator. N: # of LOC determinations reviewed made by a qualified evaluator. D: Total # of LOC determinations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: HSP 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:	☒ **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 Virtual Case Management (VCM)System has built-in edits to reject any assessments that do not meet the 29-point criteria for the Determination of Need. It also has built-in reports to determine when assessments are due or overdue. The built-in edits are ongoing. The reports may be run as often as needed.

For those functions delegated to the OA such as Level of Care 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.

In the MA's contracts with Integrated Care Program 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.

As part of the MA's quality oversight and monitoring of the waiver providers, the EQRO will perform quarterly onsite audits of the enrollee care plans through chart validation. This information will be submitted to the MA for review and analysis.

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.

b. Methods for Remediation/Fixing Individual Problems

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

15B: 1. LOC is done/corrected upon discovery; 2. If eligible, no additional action; 3. If ineligible, correction of billing and claims; 4. Individual staff training as appropriate. Remediation must be completed within 60 days.

16B: 1. LOC is completed upon discovery; 2. If eligible, no additional correction required; 3. If ineligible, billing and claims adjusted; 4. Individual receives assistance with accessing other supports and services. Remediation must be within 60 days.

17B: If it is discovered that the documentation does not support the LOC, the OA will require a justification from 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.

18B: If it is determined that the case manager is not a qualified evaluator, the LOC will be redone by a qualified case manager. If the participant is eligible, no additional correction will be required. If the participant is ineligible, the individual will receive assistance with accessing other supports and services. The OA will also provide training or technical assistance to assure that all case managers meet qualification requirements. 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 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).

AIDS Case managers inform applicants of the feasible alternatives available under the waiver and outside of the waiver at the time they apply for services and participants during each subsequent reassessment. The OA Application and Redetermination of Eligibility document and the Appeal Fact Sheet are given at the initial assessment and at subsequent reassessments.

The Application and Redetermination of Eligibility form contains information regarding the OA Home Services Program (HSP), eligibility and services. The Appeals Fact Sheet contains information regarding the participant's right to appeal any case decision. The information is reviewed and explained at initial assessment and during each reassessment. The design of the Application and Redetermination of Eligibility form requires applicants to initial each section of the document to verify an understanding of the material provided prior to a formal signature. Subsequent presentation of this information is noted in the participant's case file following each reassessment.

The Mini Mental State Examination (MMSE) is a cognitive component of the Determination of Need assessment, and is administered during each assessment and reassessment to assist in determining whether or not the participant can safely direct his or her own care. If so determined, the participant may choose among service providers, and may direct and train the caregiver. If it is determined that the participant does not have this capacity, and no responsible family member or guardian is available, then an agency employed provider, such as homemaker or home health caregiver, will be utilized.

For those served by the OA, participant preference and choice is also verified by the participant's signature on the service plan. By signing, participants acknowledge that they have been given a choice between home care and institutional/nursing facility care and waiver services.

For participants enrolled in an MCO, preference for institutional or home and community-based services will be 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 or her choice and that he or she has made an informed decision.

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.

Participants sign service plans at each reassessment, and verify that they choose to receive waiver services as an alternative to institutional care. Signed service plans are maintained by the case management agency in the participant's file for the life of the case, and at least a minimum of three years following case closure.

For participants enrolled in an MCO, the Plans will 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 OA Aids case managers serve as access points and are integrated into the communities. In some areas, the case managers interact on a daily basis, with a wide variety of individuals with varying backgrounds, cultures, and languages. The case managers have resources available to communicate effectively with persons of limited English proficiency in their community, including bilingual staff as needed, interpreters, and translated forms. Interpreter services are provided at no cost to participants.

For participants enrolled in an MCO, the Plan shall make all written materials distributed to English speaking enrollees, as appropriate, available in Spanish and other prevalent languages, as determined by the 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 Care**		
Statutory Service	**Homemaker**		
Statutory Service	**Personal Assistant**		
Statutory Service	**Respite**		
Extended State Plan Service	**Home Health Aide**		
Extended State Plan Service	**Intermittent Nursing**		
Extended State Plan Service	**Occupational Therapy**		
Extended State Plan Service	**Physical Therapy**		
Extended State Plan Service	**Speech Therapy**		
Other Service	**Environmental Accessibility Adaptations**		
Other Service	**Home Delivered Meals**		
Other Service	**In-Home Shift Nursing**		
Other Service	**Personal Emergency Response System**		
Other Service	**Specialized Medical Equipment**		

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 Care

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Services furnished on a regularly scheduled basis, for one or more days per week, or as specfified in the service plan, in a non-institutional, community-based settting, encompassing both health and social services to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a full nutritional regimen (three meals a day). This service includes transportation to and from the site; if needed.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Adult Day Care

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il 686.100

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

Every two 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):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Services consisting of general household activities (meal preparation and routine household care) and personal care provided by a trained homemaker, when the individual regularly responsible for these activities is unable to manage the home care for him or her self and is unable to manage a personal assistant. This service will only be provided if personal care services are not available or are insufficient to meet the care plan or the consumer cannot manage a personal assistant. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

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

This service will only be provided if personal care services are not available or are insufficient to meet the care plan or the consumer cannot manage a personal assistant.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Homemaker

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:

Homemaker

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il. Adm. Code 686.200

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and every two 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:

Personal Care

Alternate Service Title (if any):

Personal Assistant

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Personal Assistants provide assistance with eating, bathing, personal hygiene, and other activities of daily living in the home and at work (if applicable). These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bed making, dusting, vaccuming, which are incidental to the care furnished, or which are essential to the health and welfare of the consumer, rather than the consumer's family. Personal care providers must meet state standards for this service. Personal care will only be provided when it has been determined by the case manager that the consumer has the ability to supervise the personal care provider and the service is not otherwise covered through the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program. The personal assistant is the employee of the consumer. The state acts as the fiscal agent for the consumer.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal Assistant

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistant

Provider Category:
Individual
Provider Type:

Personal Assistant

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

1) 89 IL Adm. Code 686.10
2) Mandatory SEIU Orientation

Verification of Provider Qualifications

Entity Responsible for Verification:

Customer with assistance from case manager. DRS and HFS also verify during monitoring.

Frequency of Verification:

At time of initial employment and during annual evaluations conducted by the customer

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:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope)*:

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

Respite services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the customer. Services are limited to personal assistant, homemaker, nurse, adult day care, and provided to a consumer to provide his or her activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent.
FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. It may be provided in the following places: individuals home; or in and adult day care setting.

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 case manager and the service cost maximum determined by the DON score.

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

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

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

- ☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care
Individual	RN
Individual	Personal Assistant
Agency	Homemaker
Agency	Home Health Agency
Individual	LPN
Individual	Home Health Aide

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Day Care

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il. Admin. Code 686.100

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

Every two years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

RN

Provider Qualifications

License *(specify):*

210 ILCS 65

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Personal Assistant

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il Admin. Code 686.10

Verification of Provider Qualifications

Entity Responsible for Verification:

The customer verifies initially and DRS and HFS verify during monitoring.

Frequency of Verification:

Prior to being hired

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Homemaker

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il. Admin. Code 686.200

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

Every two years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

210 ILCS 55

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

LPN

Provider Qualifications

License *(specify):*

120 ILCS 65

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:

Home Health Aide

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

210 ILCS 45/3-206

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service
Service Title:

Home Health Aide

HCBS Taxonomy:

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

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

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

Service Definition *(Scope)*:

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

Home Health Aide in the waiver is an extended State Plan version of the "Home Health Aide" service in the State Plan and on the HFS Fee Schedule for Home Health Nursing Agencies. Services provided through the State Plan are provided on a short-term or intermittent basis. These services are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Under the State plan the first 60 days following discharge from a hospital or long term care facility do not require prior approval when services are initiated within 14 days of discharge. Home Health Aides in the State Plan are paid per visit; rather than hourly. Visits are limited to two hours or less.

Home Health Aide services, under the waiver are paid hourly and may be provided when the individual does not meet the prior approval requirements for the State Plan services. The waiver services are in addition to any Medicaid State Plan Home Health Aide services for which the participant may qualify. Home Health Aide services through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.

Services are provided by an individual that meets Illinois standards for a Certified Nursing Assistant (CNA) and provides services as defined in 42CFR 440.70, with the exception that limitations on the amount, duration, and scope of such services imposed by the State's approved Medicaid state plan shall not be applicable. Specific tasks follow:

Home Health Aides may provide basic services to persons, assisting with the assessment and care planning, nutrition and elimination needs, mobility, personal hygiene and grooming, comfort and anxiety relief, promoting patient safety and environmental cleanliness. Home Health Aide duties may include but are not limited to: checking and recording vital signs, measuring height and weight, measuring intake and output, collecting specimens, feeding, assisting with bed pans, assisting with colostomy care, turning and positioning, transferring to wheelchairs/stretchers, bathing, assisting with oral hygiene, shaving, preparing hot and cold applications, making beds, observing response to care, reporting and recording observations of person's condition, cleaning and caring for equipment, and transporting.
-

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

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customers service plan.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Home Health Aide
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Home Health Aide

Provider Category:

Individual

Provider Type:

Home Health Aide

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

210 ILCS 47/3-206, Curriculum for Training Nurse Assistants and Aides

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At the time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Home Health Aide

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

210 ILCS 55

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At the time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Intermittent Nursing

HCBS Taxonomy:

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

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

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

Service Definition *(Scope)*:

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

-
Intermittent nursing in the waiver is an extended State Plan version of the Home Health Nursing services in the State Plan and the "Skilled Nursing" service on the HFS Fee Schedule for Home Health Nursing Agencies. Services provided through the State Plan are provided on a short-term or intermittent basis. These services are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Under the State plan the first 60 days following discharge from a hospital or long term care facility do not require prior approval when services are initiated within 14 days of discharge. Intermittent or "skilled" nurses are paid per visit; rather than hourly. Visits are limited to two hours or less.

Intermittent Nursing Services, under the waiver, may be provided when the individual does not meet the prior approval requirements for the State Plan services. The waiver services are in addition to any Medicaid State Plan nursing services for which the participant may qualify. Nursing through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.

Nursing services that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or a licensed practical nurse, licensed to practice in the state. Specific tasks that may be performed are outlined below:

Licensed Practical Nurses: May provide basic medical care, under the direction of registered nurses and doctors. LPN’s duties may include but are not limited to administering basic nursing care, monitoring health by checking blood pressure, changing bandages, inserting catheters, providing basic comfort, bathing and dressing participants, as well as discussing health care with the participants and families, addressing concerns, while keeping adequate records regarding the participant's health, and reporting pertinent information to registered nurses and physicians.

Registered Nurses: May provide and coordinate care, educate participants and the public about various health conditions, and provide advice and emotional support to participants and their family members. Registered Nurses duties may include recording medical histories and symptoms, administering medications and treatments, developing the nursing plan of care or contributing to existing plans, observing and recording findings, consulting with doctors and other healthcare professionals, operating and monitoring medical equipment, assisting in the performance of diagnostic tests, analyzing the results, teaching participants and their families how to manage their illnesses or injuries, as well as explaining at home treatment options.

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

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customers service plan.
-
Services provided through the state plan are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Under the State plan the first 60 days following discharge from a hospital or long term care facility do not require prior approval when services are initiate within 14 days of discharge. Services may be provided under the waiver when the individual does not meet eligibility requirements for the state plan services.

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

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

☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Licensed Practical Nurse
Individual	Registered Nurse

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Intermittent Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

225 ILCS 65, 225 ILCS 65/55-10, 225 ILCS 55.

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Intermittent Nursing

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

210 ILCS 65

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Intermittent Nursing

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

210 ILCS 65

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

AT time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Occupational Therapy in the waiver is an extended State Plan version of the Occupational Therapy service in the State Plan. Services provided through the State Plan are provided on a short-term or intermittent basis. Under the State Plan, adults are allowed 20 therapy visits, per year. Prior approval is required. For children there are no limits. State Plan services are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. These services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Services may be provided under the waiver when the individual does not meet eligibility requirements for the State Plan services.

Service are provided by a licensed occupational therapist that meets Illinois licensure standards. Waiver services are in addition to any Medicaid State Plan services for which the participant may qualify. Occupational therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.

Specific tasks may include: instructing persons on techniques and equipment that can make daily living and working easier. The OT treats persons with injuries, illnesses, or disabilities, through the therapeutic use of everyday activities. They help develop, recover, and improve the skills needed for daily living. Duties include but are not limited to evaluating the person's condition and needs, establishing a treatment plan, determining the types of activities and specific goals to be reached, demonstrating exercises that can help relieve pain, evaluating a home or workplace, indentifying how it can be better suited to the person's health needs, educating the family about how to accommodate and care for the person, recommending special equipment, such as wheelchairs and eating aids, instructing on how to use the equipment, assessing and recording activities and progress, and reporting information to physicians and other healthcare providers.

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

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Occupational Therapist
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

225 ILCS 75

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

210 ILCS 55

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

-
Physical Therapy in the waiver is an extended State Plan version of the Physical Therapy service in the State Plan. Services provided through the State Plan are provided on a short-term or intermittent basis. Under the State Plan, adults are allowed 20 therapy visits, per year. Prior approval is required. For children there are no limits. State Plan services are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. These services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Services may be provided under the waiver when the individual does not meet eligibility requirements for the State Plan services.

Services are provided by a physical therapist that meets Illinois licensure standards. Services are in addition to any Medicaid State Plan services for which the participant may qualify. Physical therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.

Physical Therapists (PT) may perform the following tasks:
-Provide care to people of all ages who have functional problems resulting from injuries or medical conditions.

-Help people improve their movement and manage their pain, often playing an important role in the rehabilitation and treatment of patients with chronic conditions or injuries.

-Diagnose person's dysfunctional movements and design plans to address, outlining goals and planned treatment, evaluating progress, modifying a treatment plan, and educating patients and their families about what to expect during recovery from injury and illness.
-Use exercises, stretching maneuvers, hands-on therapy, and equipment to ease pain and to help increase ability to move.

-Work as part of a healthcare team, overseeing the work of PT assistants and aides, consulting with doctors and other specialists.
-

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

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan.

The amount, duration, and scope of services is based on the determination of need (DON) score and service cost maximum level as approved by the OA.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Physical Therapist
Agency	Home Health Agency

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Individual
Provider Type:

Physical Therapist
Provider Qualifications
License *(specify):*

225 ILCS 90
Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications
Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Agency
Provider Type:

Home Health Agency
Provider Qualifications
License *(specify):*

225 ILCS 55
Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Speech Therapy

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

-
Speech Therapy in the waiver is an extended State Plan version of the Speech Therapy service in the State Plan. Services provided through the State Plan are provided on a short-term or intermittent basis. Under the State Plan, adults are allowed 20 therapy visits, per year. Prior approval is required. For children there are no limits. State Plan services are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. These services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Services may be provided under the waiver when the individual does not meet eligibility requirements for the State Plan services.

Services are provided by a speech therapist that meets Illinois licensure standards. Services are in addition to any Medicaid State Plan services for which the participant may qualify. Speech therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.

Speech Therapists (ST), also referred to as Speech-Language Pathologists may perform the following tasks:
-Diagnose and treat a variety of speech, language, and swallowing disorders.

-Evaluate levels of speech or language difficulty, determining the extent of communication problems by having the person complete basic reading and vocalizing tasks or by giving standardized tests.

-Identify treatment options, creating and carrying out an individualized treatment plan.

-Teach how to make sounds and improve voices, teaching alternative communication methods, such as sign language, to those with little or no speech capability.

-Strengthen the muscles used to swallow, while counseling patients and families on how to cope with communication disorders.

-Assist with increasing the ability to read and write correctly, developing.
-

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

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Speech Therapist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech Therapy

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

210 ILCS 55

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech Therapy

Provider Category:

Individual

Provider Type:

Speech Therapist

Provider Qualifications

License *(specify):*

225 ILCS 110

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual.

Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations, which add to the total square footage of the home, are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

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

The cost of environmental modification, when amortized over a 12 month period and added to all other monthly service costs, may not exceed the service cost maximum (89 Ill. Adm. Code 679) established for the customer's case.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Environmental Modification Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:

Environmental Modification Contractor

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il. Adm. Code 686.600

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

Prior to project initiation

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Prepared food brought to the clients residence that may consist of a heated luncheon meal and a dinner meal (or both) which can be refrigerated and eaten later. This service is designed primarily for the client who cannot prepare his/her own meals but is able to feed him/herself. This service will be provided as described in the service plan and will not duplicate those services provided by personal care services or homemaker provider.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Delivered Meals Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Delivered Meals Provider

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

By Health Department where vendor is located

Other Standard *(specify):*

89 Il. Adm. Code 686.500

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

DRS obtains a copy of the HDM agency's public health certificate on an annual basis to verify that the provider meets state and local health codes. In addition, case managers contact customers on a monthly basis to verify timely and appropriate service delivery.

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:

In-Home Shift Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Service Definition *(Scope):*

Category 4:	Sub-Category 4:

The waiver provides in-home shift nursing to adults (age 21 and over). In-home shift nursing is not covered in the Illinois State plan. However, it is covered for individuals under 21 years of age, through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

In-home shift nursing is different than intermittent nursing because participants require hourly shift nursing rather than an intermittent visit, to perform a specific task.

Services are provided by RNs and LPNs that meets Illinois licensure standards for nursing services. See below for more detail.

Registered Nurses may provide and coordinate care, and educate the participant about various health conditions, and provide advice and emotional support. Registered Nurses duties may also include recording medical histories and symptoms, administering medications and treatments, developing the nursing plan of care or contributing to existing plans, observing and recording findings, consulting with doctors and other healthcare professionals, operating and monitoring medical equipment, assisting in the performance of diagnostic tests, analyzing the results, teaching how to manage illnesses or injuries, as well as explaining at home treatment options.

Nursing through the waiver, focuses on long term habilitative needs rather than short-term acute restorative needs.

Licensed Practical Nurses provide basic medical care, under the direction of registered nurses and doctors. LPN's duties may include but are not limited to administering basic nursing care, monitoring health by checking blood pressure, changing bandages, inserting catheters, providing basic comfort, including bathing and dressing , as well as discussing health care with the participants and families, addressing concerns, while keeping adequate records regarding health, and reporting pertinent information to registered nurses and physicians. The duties of an LPN may vary, depending on work setting and state. Nursing through the waiver, focuses on long term habilitative needs rather than short-term acute restorative needs.

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

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customers service plan.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	LPN
Agency	Home Health Agency
Individual	Registered Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In-Home Shift Nursing

Provider Category:

Individual

Provider Type:

LPN

Provider Qualifications

License *(specify):*

225 ILCS 65/55/10

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In-Home Shift Nursing

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

210 ILCS 55/1

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In-Home Shift Nursing

Provider Category:
Individual
Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

225 ILCS 65/60, the Professions and Occupations Nurse Practice Act

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

PERS is an electronic device that enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. This service has two components: an initial installation fee and a monthly service fee.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergency Home Response

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Agency
Provider Type:

Emergency Home Response

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

N/A

Other Standard *(specify):*

89 Il. Adm. Code 686.300

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

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:

Specialized Medical Equipment

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.
This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items, which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Suppliers
Agency	Pharmacies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment

Provider Category:
Agency

Provider Type:

Medical Suppliers

Provider Qualifications

License *(specify):*

225 ILCS 51

Certificate *(specify):*

N/A

Other Standard *(specify):*

68 Il. Adm. Code 1253

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

Providers must maintain at least $500,000 in liability insurance. A copy of the insurance certificate is obtained by case manager and maintained in customers case file. Within 30 calendar days of customers receipt of equipment, the counselor must make a home visit to verify that the equipment has been delivered to the customer or repaired, and to ensure customer satisfaction. Written verification from the customer shall be required to verify receipt and satisfaction.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Pharmacies

Provider Qualifications

License *(specify):*

225 ILCS 85

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

Providers must maintain at least $500,000 in liability insurance. A copy of the insurance certificate is obtained by case manager and maintained in customers case file. Within 30 calendar days of customers receipt of equipment, the counselor must make a home visit to verify that the equipment has been delivered to the customer or repaired, and to ensure customer satisfaction. Written verification from the customer shall be required to verify receipt and satisfaction.

Appendix C: Participant Services

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

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

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

◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☒ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

There are 30 AIDS case management offices across the state that perform case management functions for the HIV/AIDS waiver.

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):

The Healthcare Worker Background Check (HCWBC) Act (225 ILCS 46) requires designated health care employers to conduct background checks for specified employees, such as those providing direct care. The Illinois Department of Public Health (IDPH) maintains the reporting and database system. Health care employers that must provide the screenings include: In-home services (homemaker), adult day care, and home health agencies. The Act lists the convictions that disqualify them from service agency employment:
http://www.idph.state.il.us/nar/disconvictions.htm

Providers exempt from the Act, whether hired independently or through an agency, are licensed providers, such as nurses and therapists, whose licenses are under the authority of the Illinois Department of Financial and Professional Regulations.

Personal assistants (PA) hired independently by the participant are excluded from the act due to initial grass roots efforts of the disability community. Independently hired certified nurse assistants are also exempt. The State, however, offers waiver participants the option to conduct the background checks without cost when hiring the PA or independent worker. The OA case manager provides information to the participants on how to request the HCWBC. The results are returned directly to the participant.

The Illinois Health Care Worker Background Check Act (225 ILCS 46) was amended to require fingerprint background checks through a Livescan machine instead of a name only search. The fingerprint is electronically transmitted to the Illinois State Police (ISP). If no convictions are found on the database, the ISP generates an automatic e-mail notification to the provider agency submitting the request. A beneficial feature of this process, which will enhance the protection of participant's health and safety, is "Rap Back". Prior to this enhancement, since background checks were completed at the time of hire, a worker could have a subsequent conviction of which the provider agency was unaware. Under the new process, the fingerprint report will remain on the IDPH system. The "Rap Back" feature will notify the IDPH of future convictions. IDPH, in turn, will notify the appropriate provider agencies.

The IDPH verifies that home health agencies comply with the HCWBC Act during licensure reviews. The OA verifies that in-home service (homemaker) and adult day care agencies are compliant with HCWBC when conducting compliance reviews. The MA verifies compliance during onsite monitoring reviews for homemaker and adult day care agencies. The MA conducts a post-review IDPH registry check on all PAs identified as actively serving participants in the sample. The IDPH registry includes any criminal convictions that may have been reported during previous employment.

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

○ **No. The state does not conduct abuse registry screening.**

◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

The Illinois Department of Public Health (IDPH) maintains the Health Care Worker Registry (registry). Once certification is completed, Certified Nurse Assistants (CNAs) are entered onto the registry. The registry also reports criminal history and substantiated abuse, neglect or exploitation (ANE) history reported while working in a long term care setting. The ANE history remains even if the CNA moves to an inactive list on the registry. Home health agencies are required to conduct registry checks for CNAs in their employ. In-home Service (homemaker) providers are now required to conduct registry checks for abuse, neglect or exploitation as well as criminal background checks.

The OA is required to screen CNAs initially, prior to enrolling them as independent providers. A CNA would not be allowed to enroll if there was any record of administrative findings on the health care registry. Personal assistants (PAs) are not now listed on the registry, unless they were previously certified as a CNA or DD Hab Aide. OA case managers offer participants the option and the information needed to conduct the registry checks for PAs.

The health care worker can be checked on line at: https://hcwbc.idphnet.com/BgChecks.Public/Search.aspx or via a 1-800 telephone number that is provided to participants.

Registry checks are maintained in the participant's file. The MA reviews files during monitoring reviews to assure documentation is in the file if the participant is being served by a CNA. During interview, the MA asks participants whether they were informed of the right to conduct background checks. The MA and OA verify compliance during onsite monitoring reviews for homemaker agencies and adult day services. In addition, the MA and OA check the Medicaid sanction list. IDPH verifies compliance for home health agencies during licensure reviews. The MA conducts a post-review registry check on all PAs identified as actively serving participants in the sample.

Adult Protective Services Act

The State has proposed legislation to consolidate to a single entity the reporting and investigation of abuse, neglect, financial exploitation (ANE), or self-neglect of eligible adults ages 18 and older. The Department on Aging (DoA) will have the authority to receive reports and investigate ANE, expanding their current system. The DoA will establish by rule mandatory standards for the investigations and mandatory procedures for linking eligible adults to appropriate services and supports.

Along with the above, the Act provides that the DoA report to the IDPH registry the identity and administrative finding against any caregiver of a verified and substantiated decision of significant abuse, neglect, or financial exploitation of an eligible adult. In addition, it provides that in the State of Illinois, any Department, or other specified providers, shall not hire or compensate any person seeking employment, retain any contractors, or accept any volunteers to provide direct care (rather than direct access) without first conducting an online check of the person through the registry. These provisions would take effect January 1, 2014.
Certain activities are slated to be implemented upon the effective date of the Act, and others as is practical.

When a personal assistant is convicted of abuse or neglect, the OA notifies the waiver participant directly and advises them to terminate employment and find another provider. Additionally, the OA has an edit on the system to prevent payment if the PA attempts to serve another customer.

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.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

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

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

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

Case Managers provide guidance regarding the use of relatives as providers as followers: Personal care providers may be members of the individuals family (excluding parents or step-parents of minor children, spouses of customers, and minor children of a parent) when no other appropriate service provider can be located. The case file must contain documentation that a serious and ongoing effort is being made to locate another appropriate service provider; or the case manager/counselor has determined, based on documentation in the case file, that the family member is the most appropriate service provider due to the care involved, or the circumstances. Payment will not be made for services to a minor by a child's parent (or step-parent), or to an individual by that person's spouse. Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual. Time sheets are signed by the customer to verify that the services were rendered.

Customers have the authority to hire and fire personal assistants (PA), and to direct provision of PA services. PAs are reimbursed on a bi-weekly basis, and must complete and sign time sheets at the end of every two weeks period to indicate the days and hours worked. Customers then verify provision of services by signing the timesheets. By signing the timesheet, the customer acknowledges that services had been provided by the PA - as detailed on the timesheet. The customer's signature thus authorizes payment for the service by agreeing that the services had been provided.

The customer completes an annual personal assistant evaluation where the customer officially evaluates the PA's work performance, and verifies that services were provided in a satisfactory manner. The evaluation is then reviewed by the OA counselor or OA contracted case manager, and if discrepancies are noted they are reported to OA administration. Action may be taken to ensure that appropriate care is being provided to the customer which may include changing providers or utilizing a provider from the next highest level of care (i.e., utilizing a homemaker.)

Verification of care may be determined from other sources as well. For example, family members, friends, neighbors, social workers or other providers can serve as information sources concerning the customer's care. The OA counselor or OA case manager may receive a call from another family member who is concerned about a potential lack of care being provided to the customer. The OA counselor or OA contracted case manager may follow up by conducting an unannounced home visit, or schedule a nursing evaluation.

The OA counselor and OA contracted case manager also verify that services are provided in accordance with the customer's service plan. For example, during reassessments the OA counselor notes the customer's general condition, hygiene and cleanliness, considers the customer's nourishment status, and notes any odors in the house as well as cleanliness of the home. If discrepancies are identified, the counselor determines whether or not care is being provided at the appropriate level. Based upon these observations, the counselor may follow up with an unannounced home visit or arrange for a nursing assessment to determine whether the customer is receiving the proper level of care. If not, services may be changed to a homemaker.

The guidance to MCOs is the same as for the OA.

○ **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:

All willing and qualified providers who are eligible to provide services are enrolled by the OA and MA.

Over 85% of the providers in the program are personal assistants (PA) who are hired directly by the participant. Participants choose, recruit, hire, train, supervise and have the ability to fire their own PAs. Anyone selected by the participant, and who meets the requirements, may be enrolled as a provider. Other service providers, such as In-home Service (homemaker) and Adult Day Care go through a Request for Qualifications process, which is always open. The OA accepts agencies that have been approved as providers by the Illinois Department on Aging. The OA enters into a rate agreement with eligible providers. All nurses and therapists must meet the individual licensing requirements under the Illinois Department of Financial and Professional Regulations (DFPR).

Illinois Centers for Independent Living offer PA training programs. Some also maintain a list of trained providers, while others offer training to the participant on how to hire, fire and manage the PA. All participants are given the name of the centers in their area. This information is included as a component of the participant's packet. It is made available to participants at initial assessments, and at anytime if requested by the participant. The participants may contact the local center for a listing of potential PA's if they are not able to locate providers on their own.

In-home Service agencies may learn about working with the program through the Illinois Home Care Council (IHCC). This organization is a statewide, nonprofit, trade association that promotes the delivery of quality health care and supportive services in a variety of home living environments in Illinois.

All provider qualifications and requirements are found verbatim on the DHS Website, at http://www.dhs.state.il.us/page.aspx?item=27896. That website includes links to provider enrollment instructions, licensure and certification requirements, instructions for becoming a provider, relevant administrative rules, and contact information.
The page linked above contains information for providers for an array of DHS programs. Provider enrollment instructions are contained in the "IMPACT" link. There is also a "Become a Provider" link, and there are links for "Licensure and Certification" and for "Rules." Contact information is available in a link for "Rehabilitation Services Provider Information" under the "Provider Information by Division" heading.

Managed Care

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

HCBS waiver providers: 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 participants in that county.

- Adult Day Care
- Homemaker
- Home Delivered Meals
- Home Health Aides
- Nursing Services
- Occupational Therapy
- Speech Therapy
- Physical Therapy
- Specialized Medical Equipment and Supplies

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.

The following requirements apply for the remaining HCBS waiver services:

Environmental Modifications: Plans will be monitored to ensure that necessary modifications are made in a timely fashion.

Personal Assistants: The State is not dictating a network adequacy requirement, as personal assistants are hired at the discretion and choice of the beneficiary. However, Plans are required to assist enrollees in locating potential personal assistants as necessary.

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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
21C: # and % of newly enrolled certified waiver service providers who meet initial certification standards. (Note: this includes Home Health Aide, Home Delivered Meals, Day Habilitation, Pre-Vocational and Supported Employment providers). N: # of newly enrolled certified waiver srvc providers who meet initial certification standards. D: Total # of newly enrolled certified waiver srvc provdrs.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
20C: # and % of enrolled licensed waiver service providers that continue to meet applicable licensure requirements (same provider types as 19C). N: # of enrolled licensed waiver service providers that continue to meet applicable licensure requirements. D: Total # of enrolled licensed waiver service providers.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
19C:# and % of newly enrolled licensed waiver srvc providers who meet initial licensure standards (Includes: home health agencies, LPN, RN, OT, PT, ST, special medical equipment providers). N: # of newly enrolled licensed waiver srvc prvders who meet initial licensure standards. D: Total # of newly enrolled licensed waiver srvc prvders.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
22C: # and % of enrolled certified waiver service providers who continue to meet applicable certification requirements (same provider types as 21C). N: # of enrolled certified waiver service providers 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:
OA Reports: DPH Data Base

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:
26C: # and % of non-licensed/non-certified waiver service providers, by provider type, who continue to meet waiver provider qualifications (same provider types as 25C). N: # of enrolled non-licensed/non-certified waiver srvc provdrs revwd, by provdr type, who continue to meet waiver provdr qualifications. D: Total # of enrolled non-licensed/non-certified waiver srvc provdrs revwd, by provdr type.

Data Source (Select one):
Other

If 'Other' is selected, specify:
OA Reports: HSP QA Audit 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 = Confidence Interval= +/-5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
24C:# and % of non-licensed/non-certified waiver service providers, by provider type, who continue to meet waiver provider qualifications (Includes: ADC, homemaker, EHR). N: # of enrolled non-licensed/non-certified waiver srvc provdrs revwd, by prvdr type,who continue to meet waiver prvdr qualifications. D: Total # of enrolled non-licensed/non-certified waiver service prvdrs revwd, by provdr type.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: Compliance 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:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☒ **Other** Specify: Ongoing with all providers reviewed every two years	

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:
23C:# and % of newly enrld non-licensed/non-certified waiver service providers, by prvdr type, who meet initial waiver prvdr qualifications (Includes: ADC, homemaker, EHR).N: # of newly enrld non-licensed/non-certified waiver srvc prvdrs revwd, by prvdr type, who meet initial waiver prvdr qualifications.D: Total # of newly enrld non-licensed/non-certified waiver srvc prvdrs revwd, by prvdr type.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: DHS-DRS Provider Agreements

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 =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Initially	

Data Aggregation and Analysis:

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

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

Performance Measure:
25C: # and % of newly enrolled non-licensed/non-certified waiver service prvdrs by provider type, who meet initial waiver provider qualifications (Includes: PA & Env. Acc. Mod.). N:# of newly enrld non-licensed/non-certified waiver srvc prvdrs revwd, by provdr type, who meet initial waiver provdr qualifications. D: Total # of newly enrld non-licensed/non-certified provdrs revwd, by provdr type.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: HSP QA Audit 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:	☐ **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:
27C:# and % of case managers who meet waiver provider training requirements. N: # of OA and MCO case managers reviewed who meet waiver provider training requirements. D: Total # of OA and MCO case managers reviewed.

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

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

Data 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**	☐ **Weekly**	☒ **100% Review**

Agency		
☐ **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**

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

Performance Measure:
28C:# and % of homemaker agencies who meet waiver provider training requirements. N: # of homemaker agencies reviewed who meet waiver provider training requirements. D: Total # of homemaker agencies reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: Compliance 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:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify:	

	Bi-Annually	

Data Aggregation and Analysis:

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

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

The Medicaid agency, MA, will conduct routine programmatic and fiscal monitoring for 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 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.

In the MA's contracts with Integrated Care Program 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.

As part of the MA's quality oversight and monitoring of the waiver providers, the EQRO will perform quarterly onsite audits of the enrollee care plans through chart validation. This information will be submitted to the MA for review and analysis.

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.

b. Methods for Remediation/Fixing Individual Problems

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

19C:Provider will be notified by the OA of lacking documentation. Receipt of respective provider licensure documentation or disenroll. Remediation within 30 days.

20C:Remove as Medicaid provider in MMIS and require the respective provider licensure documentation be provided; Change of provider; Training for OA/MCO case managers. Remediation within 60 days.

21C:Provider will be notified by the OA of lacking documentation. Receipt of respective provider licensure documentation or disenroll. Remediation within 30 days.

22C:Remove as a Medicaid provider in MMIS and request the respective provider certification documentation; Change of provider; Training for OA case managers. Remediation within 60 days.

23C:Provider will be notified by the OA of lacking documentation. Receipt of respective provider documentation or disenroll. Remediation within 30 days.

24C:Remove as Medicaid provider in MMIS and require respective provider documentation be sumbitted; Change of provider; Training for OA/MCO case managers. Remediation within 60 days.

25C:Provider will be notified by the OA of lacking documentation. Receipt of respective provider documentation or disenroll. Remediation within 30 days.

26C:Remove as Medicaid provider in MMIS and request a receipt of respective provider documentation; Change of provider; Training for OA/MCO case managers. Remediation within 60 days.

27C:Completion of case manager training; Moratorium of new PD cases to non-certified OA/MCO case managers. Remediation within 60 days.

28C:Complete the training requirements. OA must submit a plan for how to assure training requirements are continually met. Remediation 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 Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

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

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

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

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

☒ **Other Type of Limit.** The state employs another type of limit.

Describe the limit and furnish the information specified above.

Program eligibility is based upon scoring of an assessment tool, the Determination of Need (DON). A Service Cost Maximum (SCM) 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. In certain instances, persons who are in need of exceptional medical care or services may qualify for an exceptional care rate if they may be safely maintained in the home at a cost no greater than that of institutional care.

Determination of Need
The DON assessment tool used to determine an individual's non-financial eligibility for waiver services based on the individual's impairment in the completion of the 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 waiver.

Service Cost Maximum
The DON score corresponds to a specific SCM, the total amount of funding that may be expended on services for an eligible individual. The SCM cannot exceed costs associated with nursing home placement.

The SCM for an individual may be exceeded on a monthly basis to meet a temporary increase in need for services as long as the average monthly cost for services during the twelve month period does not exceed the SCM. Such an increase in services shall not last more than three months.

Exceptional Care Rate
The exceptional care rate (ECR) is applied if indicated for individuals whose ongoing medical service needs exceed the SCM. The SCM is established by the MA. This rate is comparable to the assessed cost for nursing facility care of persons with similar medical needs and shall not be exceeded.

Participants actively participate in plan development, and are informed as to the various service options that are available to them. Participants agree to, and must sign service plans before services are implemented. The participant's physician must also approve the plan of care. The participant and their providers are always given a copy of the approved service plan.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Service Plan

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:

Case Managers are defined as:
1) a registered nurse with a current license and a Bachelor's Degree in nursing, social work, social sciences, or counseling, or four years of case management experience; or

2) a social worker with a Bachelor's degree in social work, social sciences or counseling; a Bachelor's of Social Work or a Master's of Social Work from a school accredited by any organization nationally recognized for the accreditation of schools of social work is preferred; or

3)an individual with a Bachelor's Degree in a human services field with a minimum of five years of case management experience.

4) Individuals, employed before July 1, 2005, that have been grand-fathered by the OA. They do not meet the educational requirements, but do meet the training requirements.

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:

A Registered Nurse (RN) licensed in Illinois and a bachelor's degree in nursing, social work, social sciences or counseling, or four (4) years of case management experience
A social worker with a bachelor's degree in either social work, social sciences, or counseling (a bachelor's of social work or a masters of social work from a school accredited by any organization nationally recognized for accreditation of schools of social work is preferred)
Individual with a bachelor's degree in a human-services field with a minimum of five (5) years of case management experience
In addition, it is mandatory that the Care Coordinator for Enrollees within this waiver have experience working with:
Addictive and dysfunctional family systems
Racial and ethnic minorities
Homosexuals and bisexuals
Persons with AIDS
Substance abusers

- [ ] **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.

OA Process:
The OA Home Services Program (HSP) service plan is designed to address unmet needs of the participant and to promote independence and self-direction. The case manager uses the service planning process to discuss services available to the participant under the waiver. Along with the standard service plan, the case manager also completes a Person Centered Goal addendum to the service plan. This form addresses needs outside the waiver that the participant may have, such as housing, recreation, employment, mental health. The participant is encouraged to invite individuals of their choosing to participate in the planning process. The participant also takes the lead in selecting qualified providers.

The OA HSP service plan is designed to be participant-directed. The participant, their designee, or guardian has the opportunity to actively participate in all aspects of assessment and service planning.

MCO Process:
For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning. Participants will actively participate in their own care plan development, including the selection of providers and services to receive or not receive, and will be informed prior to the service planning meeting of their authority to determine who is included in the process.

Plans will implement a person centered process for the service plan, done in partnership with the participant, their representative, or other person(s) they choose to have present or participate. The participant is encouraged to involve people important to them in this process; including but not limited to family, friends, legal counsel, and community representatives.

Prior to the completion of the initial service plan, a thorough description of the waiver program and available service benefits through the waiver will be presented to the participant by Plan care management staff.

At each step of the service development process, the participant and/or their representative(s) will be engaged by the Plan case manager to direct, participate, and finalize the service plan, including selection of the type of service(s), the service provider(s), and the frequency of the service(s), and agreement with the plan. Participants will be provided supports such as a guide for managing providers and how to complete the necessary forms for participant directed providers. Information will also be provided regarding community resources. At each assessment and reassessment and in between assessments if directed by the participant, the service plan can be changed or modified as the participant’s needs change.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

a) Development of Plan, Participation in Process, and Timing of the Plan:

OA Process:
The case manager and the participant develop the service plan, primarily based on the needs identified on the Determination of Need (DON) assessments. Plans are reviewed and revised every twelve months, or more often, as indicated by change in need.

The comprehensive assessment takes into consideration the consumer's goals and other needs, including health care needs. All services must be necessary to meet an unmet care need of the individual, or to provide relief to the primary unpaid caregiver. Services must be safe and adequate, cost-effective, and the most economical services available. The service plan is the result of a dialogue between customer and OA counselor. Although OA Counselors are responsible for determining the level of care provided to the customer, the customer has discretion in approving service providers. Both the customer and the OA counselors approve and sign the service plan. Previously, there was a requirement for physician's approval. As explained in more detail in Appendix B-2-b, the OA is working to eliminate this requirement in Section 682.100(g).

MCO Process:
The service plan will be developed by the Plans' case managers in collaboration with the waiver participant and/or their representative. At the time of the assessment and service planning, the participant is encouraged to include the person(s) of their choosing to attend a face-to-face visit with their assigned case manager. The date and time of this face-to-face visit is collaborated and based on the participant's preference. The face-to-face assessment visits are conducted in the participant's residence as this is most convenient to the participant and leads to a more accurate assessment of the participant. Changes to location are to meet the participant's needs and not for convenience of Plan staff.

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:
Service needs are identified and service plans are developed and updated based on the DON assessment tool and other needs assessments. The DON determines the participant's level of impairment in activities of daily living and whether or not the participant's individual care needs are met by family members or other supports. A comprehensive assessment is also completed to identify service needs outside of the waiver, such as housing, employment, recreation and mental health. The needs assessment is an addendum to the service plan.

MCO Process:
The Plans have comprehensive assessment tools that contain components that are used to elicit comprehensive information from the participants 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, 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. The comprehensive assessment tools used by the Plans are reviewed by the Department and its EQRO prior to implementation.

c) Informing participant of services available under the waiver:

OA Process:
Participants are provided with information on available waiver services and their rights during initial application, and during each subsequent reassessment. An appeals document is given to participants at each plan development, application, reassessment, and at any times a service is changed. Participants are also notified about available services when screened for possible nursing home placement, and are informed about their right to select in-home care as opposed to institutionalization.

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.

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 comprehensive assessment takes into consideration the participant's goals and other needs, including health care needs. All services must be necessary to meet an unmet care need of the individual, or to provide relief to the primary unpaid caregiver. Services must be safe, adequate and cost-effective. The service plan is the result of a dialogue between participant and case manager. Both the participant and case manager approve and sign the service plan. Presently, in order to assure health and safety of the customer, the customer's physician must approve the plan of care. As explained in more detail in Appendix B-2-b, the OA is working to eliminate this requirement in Section 682.100(g). 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, and the array of services have been presented to and discussed with the participant, the Plan's case manager, the participant and/or their representative(s) formulate a care plan that addresses their goals, the strengths and barriers/risks in consideration of these goals, and the mutually agreed upon activities for their achievement. As this is participant-centric, personal preferences are integral to the development of the service plan. The service plan includes the type, amount, frequency, and duration of waiver services, and may include services and supports not covered under the waiver.

As part of its work on behalf of the MA, 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.

MCO participants are also provided the "Points to Ponder" document to assist in making decisions on self-directed services. All participants (MCO and FFS), are required to complete personal assistant evaluations. The MCO and the OA are responsible for assuring the evaluations are completed and for handling any issues of concern.

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

OA Process:
Services are coordinated to assist persons in becoming as independent as possible. The case manager and the participant work together to design a comprehensive set of services that will meet the participant's needs. The service plan is approved by the participant and case manager, and signed by both. In an effort to monitor service provision and address potential gaps in service delivery, the participant is contacted at least once per month by the OA case manager. Any disruption of service may then be addressed by the case manager through working cooperatively with the participant to develop strategies to address any unmet service needs.

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:
During the plan development process the case manager discusses services and choices of providers. The service plan designates the service provider, the types of tasks based on the need, and the hours designated for the tasks. In addition the participant is given instructions on how to request a change in the plan if the participant's situation changes. Case managers explain to participants at all assessments about the need to notify the case manager at any time that there is a change in his or her living (or medical) situation that may affect services.

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.

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

OA Process:
Service plans are updated at least every twelve months, and more often if indicated by a change in need. Case managers contact the participant at least monthly, with a face to face contact bi-monthly, to verify the provision of services and to discuss any changes in the living arrangement or medical situation. If the participant's situation changes to the extent that services need to be revised, the case manager may complete a temporary service plan addendum that modifies the service plan until the next reassessment is completed. If the change results in a cost for services that exceeds the SCM, the case manager will complete the reassessment. Participants have the right to appeal any decision made by the case manager concerning their case.

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 and services needs, and their preferences and goals. Based on the assessment, the care coordinator works with the participant to develop a service plan that reflects needs and choices. The participant's family or legal representative may be involved in every step of the assessment and planning process, as the participant chooses.

After each comprehensive assessment is completed, in which the member's current status and needs are identified; a new service plan will be 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 will 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 will complete 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 will obtain the waiver participant's signature of agreement on the service plan and will offer 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.

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).

As part of its work on behalf of the MA, 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.

The service plan shall include signatures of the HSP counselor or MCO care coordinator, the customer, and each individual provider and or agency provider who shall deliver the services identified in the service plan. Everyone signing the service plan will receive a copy

In order to comply with requirements detailed under 441.301(c)(2)(ix)-(x), an Amendment to 89 IAC 684.10 will be

developed to provide language that will specify which service providers are not responsible for implementation of the plan and will not have to sign and will not receive a copy of the plan.

As a condition of approval for the HIV/AIDs waiver, a corrective action plan (CAP) addressing compliance with Person Centered Planning requirements in the Final Rule by requiring that the person centered plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for it implementation. In addition, providers responsible for the plan's implementation are given a written copy of the plan when it is developed and updated. The PCP CAP will be completed and fully implemented by December 31, 2018.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

OA Process:
The participant is assessed with respect to risks and potential risks, and the state's ability to address any identified risks by the service plan. The case manager determines severity of impairment through participant interview and the supporting clinical information. The participant's need for service is then determined, as well as whether or not a service plan can be developed that will effectively address potential risks.

During the service planning process, the case manager must address the consequences of negative choices, which may have potential risks, document the issues of concern and the decisions made. This discussion is maintained between case manager and participant during initial assessment, and subsequent reassessments.

Services may be provided to the participant only when they are safe and adequate. Case managers must review all available information when determining the risks associated with provision of services, including input from the participant, medical and psychological information, and anecdotal information from other sources, personal observation and past experience with the participant. The scoring on the Determination of Need must match this information, and if not, the case manager must resolve any discrepancies.

The participant must agree that the services will safely and adequately meet his or her needs, and signify this by signing the service plan. Participants are encouraged to completely participate in plan development. No plan may be implemented unless approved by the participant and their designee or guardian, if indicated. At initial assessment and during subsequent reassessments, the participant is informed of his or her rights and responsibilities, and must be forthcoming about the level of unpaid care that is or is not available. Once the plan has been implemented, the case manager contacts the participant at least monthly, with a face to face contact bi-monthly, to determine consistency of service provision, and also to determine whether or not level of care continues to meet participant's needs. The participant is instructed to notify the case manager of any changes that may affect eligibility and provision of services.

Depending upon level of services provided, a backup plan may be required. If a personal assistant (PA) or other independent provider is used, at least one additional PA or independent provider must be identified to serve as a back up in the event that the primary worker is unable to serve the participant. If a participant is receiving services from an agency, those safeguards are built into the level of service as agencies must maintain proper backup personnel to fill vacancies. Previously, there was a requirement for physician's approval. As explained in more detail in Appendix B-2-b, the OA is working to eliminate the physician certification requirement in Section 682.100(g).

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 will incorporate into the service plan, strategies to mitigate risks identified, including the backup plan and arrangements for back-up.

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 may increase and serve as barriers to the members' ability to live as safely and independently as possible. Risks may include, but are not limited to, substance abuse, non-adherence to treatment, and environmental safety concerns. 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:
Approximately 85% of the providers in this program are personal assistants (PAs) that are hired and trained by the participant. Case managers assist participants in identifying potential providers. When a PA is chosen, the case manager gives the participant a Customer Packet that includes information on self-direction: Personal Assistant Handbook, Customer's Rights and Responsibilities document, Personal Assistants Standards forms and Medicaid Provider Agreement. OA case managers receive intensive training on the array of services provided by the waiver. Additionally, case managers receive the rates and fees table that lists all service descriptions. If a traditional provider is chosen, case managers share a list of approved providers with the participant, who then chooses from the list.

The OA case manager provides a brochure that lists all services in the program for all new applicants. There is also a notation on the Home Services Application and Redetermination of Eligibility Agreement, IL-488-2450W (R10/07) that states that the participant received the list of services.

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 case manager'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 complex 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 case management staff will support the participant in selecting a provider to meet their needs if the participant does not have a preferred provider identified. The Plan maintains a current list of qualified and contracted service providers which is made available to participants upon request. The participant is also educated that the Plan's provider list is available on the Plan's website.

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):

On an annual basis, the MA selects a statistically valid sample for conducting onsite record reviews to assure compliance with federal assurances. The MA uses a representative 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.

The MA reviews a sample of service plans during the monitoring reviews. Service plans are reviewed for compliance with state and federal regulations. The MA sends reports of findings to the OA with recommendations for remediation. Information is shared during quarterly quality meetings.

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.

OA Process:

OA AIDS Administration Unit (AAU)

The OA AIDS case manager, as the first line contact with the participant, is responsible for monitoring the implementation of the service plan and participant health and welfare. The case managers contact the participant once per month by telephone, with one face-to-face contact every other month.

The AAU annually conducts service plan reviews, including monitoring implementation. The HIV AIDS program managers conduct case reviews at each case management office, reviewing a minimum of three cases up to a full caseload of each case manager. Case reviews are discussed and technical assistance and follow-up is provided as needed for remediation. Case reviews are in addition to the representative sample monitoring of performance measures.

Case reviews include an evaluation of the following:

Eligibility/Ineligibility: Case documentation must verify determination of eligibility or ineligibility. Additionally, case information must document completion of timely semi-annual reassessments. Closed cases must have documentation that clearly justifies reason for closure.

Narrative: The Narrative must reflect a comprehensive dialogue between the participant and interviewer. Content is reviewed to determine quality, and to assess applicability to the program. Information obtained in the Narrative should provide the foundation to support the assessment score and service provision. Any increase or decrease of services authorized by the service plan must be described and justified.

Comprehensive Service Planning: The Service Plan must reflect the comprehensive service needs of the participant. The time and frequency of tasks identified on the Service Plan must reflect participant limitations, and existing supports available in the home and community. Documentation must reflect the quality of case management by indicating the degree of interaction with the participant and caregivers, coordination with community supports, and resolution of identified problems or issues occurring in the case.

Financial Accountability: Case documentation must support the purchase of assistive equipment or environmental modification, and ensure that purchases were completed with adherence to program rules and regulations. Fraud or other financial irregularities must be documented and reported to appropriate administrative personnel. All case management staff must ensure that services do not exceed the service cost maximum assigned to the case, and that all paid billings are processed in accordance with State of Illinois purchasing guidelines.

Participant-Driven Issues: A variety of items are reviewed under this section including: assurance that assigned services are provided to the participant, with appropriate documentation; participants have been provided with the information about how to appeal case decisions; proper reporting of abuse and neglect and unusual incidents; participant health and safety. Documentation must provide a description and resolution of any identified concerns.

OA Quality Assurance (QA) Unit Case Management Agency Site Visits

The OA QA Unit conducts separate monitoring from the AAU. A statistically valid random sample is selected by the MA and the sample is divided between the MA and OA for monitoring compliance through performance measures, including service plan implementation and health and welfare.

The OA QA Unit reviews the performance measures, as indicated in the Quality Improvement sections of the waiver, develops a report, and shares with the following entities: 1) the individual case management office, 2) the OA, Regional office, and 3) the OA AIDS Administration Unit. The individual case management offices are then responsible for making individual corrections. The AAU is responsible for follow up and assuring that the corrective actions are implemented.

The MA and OA meet quarterly to discuss quality outcomes and develop strategies for quality improvement. On an annual basis, the OA QA Unit, the AAU and the MA develop statewide summary reports of monitoring activities. The reports are shared during QI meetings to discuss trends, patterns, remediation and quality improvement methods on a system-wide level. Results between the different monitoring entities are also shared to compare and contrast findings

among the different entities.

MA oversight monitoring:

The MA program monitoring activities include: randomly selected portion of the representative sample. Information is gathered through participant record and care plan reviews and interviews; and selected case management and provider reviews and interviews. All findings are reported to the case management or provider during the review and to OA for remediation.

Service Plan Process and Implementation:
During the review of records or interviews, the MA monitors the service plan for the following: During the on-site visits, the MA interviews participants to verify that services are delivered as approved and paid for under the service plans and meet the participants' needs. The MA verifies case manager contact is at least once per month by telephone and face-to-face every other month, as required by the waiver. Case notes are reviewed to identify changes in service needs and whether they resulted in service plan revisions if warranted. Worker timesheets are reviewed to ensure the services delivered are consistent with the service plan.

The MA compares the DON assessment of needs and available supports to the participant's service plan to ensure that unmet needs identified on the assessment are addressed. The reviews include evidence of participant involvement in the service plan process and that the participant was informed of rights and choice of services and providers.

Effectiveness of back up plans:
The MA reviews the service plan for evidence of a backup plan. The MA verifies with the participant during interview that the backup plan meets participant needs.

Participant health and welfare:
The MA ensures that processes are in place to identify, address, and report abuse, neglect and misappropriation of funds. Incidents, complaints and the reporting processes are reviewed through record review, participant interview and case manager interviews. The MA checks the Illinois Department of Public Health (DPH) Health Care Worker (HCW) Registry post review for all persons providing direct care to waiver participants in the sample.

Participant access to non-waiver services in the service plan, including health services: The MA verifies that the Comprehensive Needs Assessment is in the record and corresponds with the current service plan. During the participant interview, the MA asks whether health conditions or needs exist that are not addressed in the service plan, whether the needs were reported to the case manager, and whether referrals were made or other resources were used.

MCO Process:

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 Plan 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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

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

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

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk***

factors) and personal goals, either by the provision of waiver services or through other means.

Performance Measures

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

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

Performance Measure:
29D: # and % of OA and MCO participants' service plans that address all personal goals identified by the assessment. N: # of OA and MCO service plans reviewed that address all personal goals identified by the assessment. D: Total # of OA and MCO service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; EQRQ 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 Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: HSP QA Audit 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:	☒ **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:
32D: # and % of OA and MCO survey respondents in the sample who reported they receive services they need when they need them. N: # of OA and MCO survey respondents who reported they receive services when needed. D: # of OA and MCO survey respondents in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports: CAHPS 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: CAHPS Guidelines
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: Satisfaction 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:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify:

		10% of the population selected randomly by region
	☐ **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:
31D: # and % of OA and MCO participants' service plans that address risks identified in the assessment. N: # of OA and MCO service plans reviewed that address risks identified in the assessment. D: Total # of OA and MCO service plans reviewed.

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: HSP QA Audit 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 = Confidence Interval = +/- 5%
☐ **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:

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

Performance Measure:
30D: # and % of OA and MCO participants' service plans that address all participant needs identified by the assessment. N: # of OA and MCO service plans reviewed that address all participant needs identified by the assessment. D: Total # of OA and MCO service plans reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: HSP QA Audit 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:	☒ **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 = 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 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:
34D # and % of OA and MCO participants who received 1 contact per month, with 1 contact face-to-face bi-monthly, by their case manager in an effort to monitor service provision and address potential gaps in service delivery. N:# of OA and MCO participants reviewed who received 1 contact per month, with 1 contact face-to-face bi-monthly. D: Total # of OA and 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 Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: HSP QA Audit 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:	☒ **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:
33D:# and % of OA and MCO participants' service plans that were signed and dated by the waiver participant and the case manager. N: # of OA and MCO service plans

that were signed by the waiver participant and the case manager. D: Total # of OA and 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 Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: HSP QA Audit Report

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:	☒ **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**

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

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

Performance Measures

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

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

Performance Measure:
36D: # and % of OA and MCO waiver participants that received updates to service plans when participants needs changed. N: # of OA and MCO waiver participants reviewed that received updates to service plans when participants needs changed. D: Total # of OA and MCO waiver participants identified whose needs changed.

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: EQRO/MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Subset of representative sample
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: HSP QA Audit 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: Subset of 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:

Performance Measure:
35D: # and % of OA and MCO waiver participants who have their Service Plan updated every 12 months. N: # of OA and MCO waiver participants reviewed who have their Service Plan updated every 12 months. D: Total # of OA and MCO waiver participants with service plans due during the period reviewed.

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 =
☒ **Other** Specify: EQRO/MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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:

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:
37D: # and % of OA and MCO participants who received services in the type, scope, amount, duration, and frequency as specified in the service plan. N: # of OA and MCO participants reviewed who received services as specified in the service plan. D: Total # of OA and 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 Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: HSP QA Audit 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:	☒ **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:
38D:# and % of OA and MCO survey respondents in the sample who reported the receipt of all services listed in the plan of care. N: # of OA and MCO survey respondents who reported the receipt of all services listed in the plan of care. D: # of OA and MCO survey respondents in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports: CAHPS 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: CAHPS Guidelines
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: Satisfaction 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:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify:

		10% of the population selected randomly by region
	☐ **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/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:

39D:# and % of OA and MCO participants records with the most recent plan of care indicating the participant had choice between waiver services and institutional care; and between/among services and providers. N:# of OA and MCO partcpt recs revwd with a signed POC that indicates partcpt had choice between waiver srvcs and between srvcs and prvdrs. D:Total # of OA and MCO partcpt recs revwd.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: HSP QA Audit 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:	☒ **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: 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:	☒ **Annually**

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

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

The Medicaid agency, MA, will conduct routine programmatic and fiscal monitoring for 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 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.

In the MA's contracts with Integrated Care Program 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.

As part of the MA's quality oversight and monitoring of the waiver providers, the EQRO will perform quarterly onsite audits of the enrollee care plans through chart validation. This information will be submitted to the MA for review and analysis.

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.

b. Methods for Remediation/Fixing Individual Problems

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

29D:If plans do not address required items, the OA/MA will require the plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.

30D:If plans do not address required items, the OA/MA will require the plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.

31D:If plans do not address required items, the OA/MA will require the plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.

32D:If identifying information is available for individual surveys 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.

33D:If plans are not signed by appropriate parties, the OA/MA will require the plans be corrected. The OA/MCO may also provide training in both cases. Remediation must be completed within 60 days.

34D:If participants do not receive monthly contact by case manager, with at least one face to face contact bi-monthly, the OA/MA will require the participant be contacted and provide training of case managers. Remediation must be completed within 60 days.

35D:If service plans are untimely, the OA/MA will require completion of overdue service plans and justification from the case manager. The OA/MCO may also provide training of case managers. Remediation within 60 days.

36D: If service plans are not updated when there is documentation that a participant's needs changed, the OA/MCO will require an update and justification from the case manager. The OA/MCO may also provide training of case managers. Remediation within 60 days.

37D: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.

38D:If identifying information is available for individual surveys 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.

39D:The OA/MCO will assure that choice was provided as shown by the correction of documentation to indicate customer choice. 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:	☒ **Annually**

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Illinois has offered participant-direction in the OA Home Services Program since the early 1980s and in the HIV/AIDS waiver since its inception in 1990. Participants may either hire their own service providers or use an agency provider. Participants are encouraged to use their own service providers, whenever possible.

Most participants choose to hire personal assistants (PA) as their provider. PAs are individual service providers that are hired by and directly supervised by participants. In addition, if a PA is not performing to participant satisfaction, the participant may take disciplinary action against the PA, including discharge. As the employer, participants manage most every aspect of the employment relationship with their personal assistant (PA); participants are responsible for identifying, interviewing, hiring, managing, disciplining, and ending the employment relationship. Participants have the right to the direct services rendered by the Personal Assistant and determine under what circumstances anyone may enter their homes. Specific discipline of a PA by a participant is not prescribed by the Home Services Program; however, the program does provide guidance to the participant on how to properly manage a PA. Participants are not allowed to harass or discriminate against their PAs. The PAs are provided due process rights and represented by the Service Employees International Union (SEIU). Additionally, participants complete annual reviews on PAs, and if dissatisfied with the work can indicate so on the review.
Participants work with PAs to arrange work schedules to address services identified on the service plans, and to meet participants' scheduling needs as well. Participants may either directly train PAs in effectively meeting their particular services needs, or may coordinate PA training through another resource.

As the employer, the participant must sign timesheets to approve and verify the hours that the PA has worked. Signed timesheets for the four Chicago districts, which serve the majority of those in the HIV/AIDS waiver, are sent to the OA Aids Administration Unit (AAU) for further verification. In Central and Southern IL, timesheets are forwarded to the OA Home Services Program district office for processing. The OA has developed a payroll system to pay independent providers twice monthly. The payroll system withholds unemployment, FICA, other employee benefits and other deductions as requested by the provider.

PA services are provided in accordance with the plan of care. In the event that it is determined that a participant is unable to appropriately supervise a PA, the service may be changed to homemaker, or another service. When this occurs, the participant is advised that PA services will continue if he or she disagrees with this decision until the appeal process has been exhausted. Conversely, PA services would not continue in the instances of abuse/neglect/financial exploitation, fraudulent activity, or if PA services are not yet begun. Homemaker agencies provide a level of service similar to that of a PA.

Homemaker agencies are utilized when participants do not have the capacity to appropriately supervise a PA, or when a PA cannot be located for the participant. Homemakers are supervised by their respective homemaker agency. Again, participants may select the agency of their choice. Homemaker services are provided in accordance with the plan of care, and in accordance with provisions specified in a rate agreement with the OA.

Other individual (non-agency) providers may include home health aide, licensed practical nurses, registered nurses, or therapists. Participants may still opt to select their preferred provider for nursing care or therapy, however due to the clinical nature of nursing and therapies, participants have some limits to service supervision provided by these individual providers. Clinical services are only provided as prescribed by the physician. Although the participant exercises self-direction as indicated above, the actual provision of clinical services must be provided in accordance with clinical standards and must be prescribed. Services are provided in accordance with appropriately designed and approved clinical plans.

For other agency-provided services, participants still have the option of determining which service provider is authorized to provide services, but may not have direct supervisory responsibility over non-PA level of care. For example, participants have the right to select specific agencies and service providers to provide services according to level of care identified on the service plan. Services provided by agencies are provided in accordance to the participant’s service plan, and with respect to contractual or agency standards, depending upon the level of care. Services provided by agency personnel are supervised by management staff from respective agencies.

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning. Participant direction is the cornerstone of the ICP demonstration project. Plans allow participants, who elect to and can safely direct their own services, the opportunity and supports needed. Opportunities for participant direction, at minimum remain the same as described above. This includes that participants will actively participate in their own care plan development,

including the selection of providers and services to receive or not receive, and maintain employer authority.

There are no differences between the MCO and FFS in the delivery of participant directed services.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- (●) **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ( ) **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ( ) **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- [x] **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- [ ] **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- [ ] **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ( ) **Waiver is designed to support only individuals who want to direct their services.**
- (●) **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ( ) **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

During the initial assessment,subsequent reassments, and the service planning process, the case managers provide information to the customers about participant directed services and choice of worker. Customers are given a Customer Packet, which includes: a Personal Assistant Packet; guidelines for self-directed care; Rights and Responsibilities brochure, which includes the right to appeal, informal resolution, and information about the Client Assistant Program (CAP); Employment Agreement; Optional Criminal Background Check form; and a Medicaid provider agreement.

Information about participant direction opportunities is provided at time of application and initial determination of eligibility, annual redetermination of eligibility assessments, service planning, and upon request. The Application and Redetermination of Eligibility Agreement form is reviewed with the participant during every eligibility assessment.

When determined able to manage an Individual Provider, participants are provided with a “Customer Packet” with information about self-directed services, managing personal assistants, and other services, information about participant rights and responsibilities, and appeal information.

The personal assistant packet includes the following: the customer and PA employment agreement form, which describes the relationship between the PA and customer and the employment arena and the PA standards form, which allows the PA to list their qualifications and work experience, related to the position. Copies of the PAs social security card and photo ID are also included to identify the worker as required by labor laws.

The participant also receives the HSP Application and Redetermination of Eligibility Agreement that contains information such as: customer rights and responsibilities, abuse and neglect reporting, choice, and services. Case managers review this form with participants when there is a change in service or minimally, at each annual redetermination. Participants initial each section and sign the agreement indicating that the case manager has reviewed it with them and that they understand the information.

If an individual elects to change from an agency to a personal assistant, the case manager sends a Payment Request form to the agency to terminate services. This form outlines the services and the termination date. The participant then selects the PA and the documents in the PA packet are completed.

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning. The Plan care coordinator is responsible for furnishing the information as part of the service planning process to inform decision-making concerning participant direction. The content of the information at minimum remains the same as described above.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The state does not provide for the direction of waiver services by a representative.**
- ◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A customer (participant) is considered anyone who: 1) has been referred to the Home Services Program (HSP) for a determination of eligibility for services; 2) has applied for services through HSP; 3) is receiving services through HSP; or 4) has received services through HSP.

If the participant is unable to satisfy any of his or her obligations under the waiver, including, without limitation, the obligation to serve as the employer of the PA, the participant's parent, family member, guardian, or duly authorized representative may act on behalf of the participant and is included within the definition of "participant", as used throughout this Part.

A legally responsible family member is a spouse, parent of a child who is under age 18 or a legal guardian of an individual who is under age 18. Waiver services may be directed by a legally responsible family member of a participant.

Non-legal representatives will only participate in the assessment process when so designated by the participant, and also will only participate in the decision-making process when approved by the participant. Safeguards are in place to protect the participant when non-legal representatives are involved. These safeguards are described below:

Case managers contact participants once per month by telephone. Every other month, case managers are required to have a face-to-face visit. This visit may be in the home, the case management office, clinic or another mutually agreed upon location. Case managers make efforts to speak to participants privately, without the non-legal representative and are trained to ask questions and make observations about the participant’s well being.

If the participant reveals or there are suspicions of abuse, the case manager has several options to pursue, which include assisting the participant with setting up a Payee for their benefit check; referring the participant to the AIDS Legal Foundation or Prairie State Legal Services for Power of Attorney provisions, or other protections; and contacting the Office of the Inspector General if there are any abuse, neglect or exploitation issues.

Participants are invited to participate in all aspects of their assessment and service planning process to the best of their ability to understand and contribute to the process. Legally responsible parties or legal representatives may be part of the assessment and service planning process. Participants who do not have a legal representative are offered to invite a representative to each assessment and reassessment visit to support or assist them during the assessment and service planning process. The participant may also wish to have a non-legal representatives assist them in decision making or navigating the waiver and health plan services.

If the participant is able to direct their care, then non-legal representatives will participate in the assessment, service planning, and decision-making process only when approved by the participant.

Participants who are not able to direct their own care may have non-legal representatives support and assist in the assessment and service planning process if they are acting in the best interest of the participant. Safeguards in place to ensure non-legal representatives act in the best interest of the participant include the quarterly assessment by the Plan’s case manager to confirm members needs are being met according to the service plan, informal supports are being provided as previously identified in the assessment, other contacts done by the case manager to ensure service implementation and well-being for a participant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Personal Assistant	☒	☐
Home Health Aide	☒	☐
Respite	☒	☐
In-Home Shift Nursing	☒	☐
Intermittent Nursing	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☒ **Governmental entities**

☐ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Illinois does not procure an FMS. FMS are provided by a state agency, the Illinois Department of Human Services, Division of Rehabilitation (DHS-DRS), the operating agency (OA). FMS is provided by the OA in accordance with standard accounting and auditing procedures, and FMS are aligned with fiscal management procedures utilized by the Medicaid agency (MA), Healthcare and Family Services, Medicaid program. This includes quality assurance procedures to verify service are provided and paid in accordance with policy, rules, and regulations.

The OA administers a payroll system for independent providers. The Internal Revenue Service recognizes the participant and the DHS-DRS as the co-employer of record. The participants must sign service calendars to verify the hours worked. The independent (non-agency) provider sends the hours worked to the AIDS Administration Unit for review and approval. The Aids Administration unit then enters the payment onto the Virtual Case Management System that includes internal edits to assure that the correct rates and the claims are within the service cost maximum. The OA state operated payroll system pays independent providers twice monthly. The payroll system withholds unemployment, FICA, other employee benefits, and other deductions as requested by the provider. All workman's compensation claims come through the OA and are processed by the Illinois Department of Central Management Services, Risk Management. The OA case management system provides guidance and oversight of participants hiring independent providers. The Client Assistance Program provides advocacy and guidance to participants.
-

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

No external agencies are utilized for FMS. This is a function of the operating agency.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [ ] **Maintain a separate account for each participant's participant-directed budget**
- [ ] **Track and report participant funds, disbursements and the balance of participant funds**
- [ ] **Process and pay invoices for goods and services approved in the service plan**
- [ ] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☐ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☐ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The FMS is operated by the State of Illinois. Monitoring occurs as a routine function of the fiscal oversight processes in both the OA and the MA.

The MA receives and reviews the DHS-DRS quarterly administrative claim that includes administrative expenditures of the OA. Each quarter, the entire claim is reviewed for variances from prior quarters. For instances of variances, the MA requests and reviews a detailed expenditure documentation to assure that the costs are adequately supported. Any discrepancies are corrected in the next quarterly claim.

In addition, as referenced in Section I-1 (b) of the waiver application, the MA conducts post claim review of waiver claims and reviews rates from the perspective of correct rate applied for a specific waiver service.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The AIDS case managers furnish support for participant direction. There are 30 AIDs case management offices statewide. Case management is maintained through rate agreements with the OA. AIDS case managers are responsible for providing information and support to participants. They explain participant rights and responsibilities to the participants, the purpose and scope of the program, and provide information concerning the types of available services.

At initial eligibility determination, participants are informed of the variety of services available through the Customer Guidance on Rights/Responsibilities/Appeal Procedures and the Home Services Program Appeal Fact Sheet (HSP-1) and are offered this information at subsequent reassessments. This document provides detailed information on waiver services, and is explained to the participant during assessments.

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning. The Plan care coordinator is responsible for providing the information and assistance in support of participant direction. During training with the MCOs, the OA provides the MCOs with a document called, “Points to Ponder". This document discusses items that should be considered when assisting a participant with choosing an independent provider.

The OA and the MCO both require that participants complete personal assistant evaluations, on an annual basis. The OA and the MCOs are responsible for assuring the evaluations are completed, and are responsible for handling any issues of concern.

There are no differences between the MCO and FFS in the monitoring of enrollees who self-direct services. These enrollees have an equal opportunity of being selected in the representative sample.

The Client Assistance Program also known as the CAP program is available to all participants (both FFS and MCO).

Customers are informed of the type of availability of services offered through the Persons with HIV/AIDS waiver. Additionally, customers have the right to choose their service providers, for example which physician they will see, or which HSP approved vendor will provide them with goods or services (Section 677.40 Freedom of Choice). At initial eligibility determination, customers are informed of the variety of services available through the "Customer Guidance on Rights/Responsiblities/Appeal Procedures (HSP-1)" and are offered this information at subsequent reassessments as well. This document provides detailed information on waiver services, and is explained to the customer during assessments.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Speech Therapy	☐
Personal Assistant	☒
Home Health Aide	☒
Specialized Medical Equipment	☐
Respite	☒
Adult Day Care	☐
Home Delivered Meals	☐
Occupational Therapy	☐
Physical Therapy	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Emergency Response System	☐
In-Home Shift Nursing	☒
Intermittent Nursing	☒
Homemaker	☐
Environmental Accessibility Adaptations	☐

☒ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

There are two primary entities that furnish supports to consumers regarding participant direction, the AIDS case managers and the Centers for Independent Living (CIL). The OA AIDS Administration Unit provides ongoing support and consultation to case managers in order to facilitate their support of participant direction.

The CILS are located throughout the state and provide training for consumers on how to manage their personal assistants.

At each reassessment the case manger discusses the rights and responsibilities related to having a personal assistant. Each consumer receives a document titled "Points to Ponder", that discusses the issues of hiring family members as caregivers. Case managers assess performance of independent providers through the monthly contacts.

The OA AIDS Administration unit and the OA Quality Assurance unit conduct annual reviews of participant records. The OA AIDS Administration Unit annually reviews 100% of personal assistant evaluations, completed by participants. If issues are found, contact is made with the participant, and the issues are addressed.

The OA AIDS Administration Unit and the AIDS Foundation of Chicago, meet quarterly to discuss issues regarding the waiver. Information and assistance with participant direction can be discussed in this forum.

The MA annually conducts 40 interviews, in addition to the 100 record reviews that ask specific questions about services. The OA and MA meet quarterly to discuss monitoring findings and overall quality management issues. Issues identified through monitoring are discussed and addressed both individually and systemically.

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning and supports are provided as waiver case management. The Plan care coordinator is responsible for providing the information and assistance in support of participant direction.. The MA monitors the performance through analysis of reports, onsite monitoring, desk audits and interviews for those waiver participants enrolled in an MCO. Participants in MCOs are included in the representative sampling.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Illinois offers an independent entity called the Client Assistance Program (CAP). This program helps people with disabilities receive quality services by advocating for their interests and helping them identify resources, understand procedures, resolve problems, and protect their rights in the rehabilitation process, employment, and home services. CAP provides services through advocates and attorneys located throughout Illinois. All CAP services are free and confidential.

CAP services include:

·Assisting individuals with problems they experience in seeking or receiving services.

·Trying to resolve issues at the lowest possible level (such as the local office), using advocacy skills, dispute resolution, and negotiation.

·Assisting or representing individuals in their appeals of decisions regarding services and, if necessary, represent them in court.

·Working with the department, community groups, and advocacy organizations to resolve system problems.

·Providing public education programs on the rights of individuals with disabilities and other related areas.

·Providing information and referral to related services.

The OA provides each participant with a copy of the Home Services Program Appeal Fact Sheet (HSP I) initially, at each reassessment and upon request. The HSP I includes information on the right to appeal. In addition, the document includes information about the Client Assistance Program (CAP). CAP is a statewide program designed as an advocate program for HSP and Vocational Rehabilitation consumers.

When a complaint is presented to the CAP, the CAP representative brings the participant's complaints to one of the three OA HSP zone offices. A CAP representative is assigned to each zone and is responsible for handling complaints and questions in his or her zone. The CAP representatives meet weekly to insure consistent and appropriate responses.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

At initial assessment and at each subsequent reassessment, participants are provided their rights and are offered the choice to either continue or discontinue services. When participants sign the service plan they acknowledge that they have been provided with alternatives to waiver services, and have opted to remain in the home through the provision of in-home care.

In the event that participants decide to no longer receive waiver services, alternate service options are reviewed with the participant up to and including possible institutional placement. In order to assure the health and safety of these participants, waiver services continue until the participant is successfully transferred to another support program, or has been placed in a nursing home or similar institution.

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning and implementation monitoring. The Plan care coordinator is responsible for providing needed supports for participant direction. The Plan coordinator will assist the participant to choose alternate services and ensure supports are in place for continuity of care, health and welfare during the transition.

All enrolled waiver participants will be offered the opportunity to direct none, some, or all of their services. A waiver participant who selects to direct none or some of their services can obtain their waiver services through provider-managed services.

All waiver participants who select to direct their services can at any time terminate that choice and transition to provider-managed services. In order to assure the participant's health and safety and no interruption in services the Plan will coordinate the transition from self-direction to provider-managed services to assure no break in services.

Voluntary terminations will be recorded on the participant's service plan and will be indicated by the participant's approval of the new service plan.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Services provided by a personal assistant will only be provided when it has been determined by the OA case manager that the participant has the ability to supervise the personal care provider. In cases where the case manager determines that the personal assistant cannot meet the needs in the care plan, or the participant cannot manage a personal assistant, or the participant's health or safety is otherwise at risk by using the personal assistant, the case manager will offer in-home services (homemaker) through an agency provider. These services will be provided in accordance with the plan of care.

For participants enrolled in an MCO, the Plan care coordinator will provide the necessary supports to assure continuity of services and participant health and welfare during the transition.

Services provided by a personal assistant will only be provided when it has been determined by the Plan's case manager that the participant has the ability to supervise the personal care provider.

In cases where the Plan's case manager determines that the personal assistant cannot meet the needs of the member outlined in the service plan, or the participant cannot manage a personal assistant (and if the participant has no reliable person available to assist in managing the personal assistant), or the participant's health or safety is otherwise at risk by continuing to use a personal assistant, the Plan case manager will consider the need to terminate the participate directed service involuntarily.

Prior to terminating any participant directed service the Plan case manager will send the participant a Notice of Action that provides the member with information as to why their service is being terminated or reduced and includes their rights to appeal and fair hearing process.

The Plan case manager will replace the participant directed service with comparable agency directed services and do so timely to prevent a gap in service or care. Participants maintain the right to choose an agency provider in the Plan's contracted provider network. The service plan will be updated to reflect any changes.

The OA and MCOs use a standard process for determining the customer's ability to self-direct. If the customer is unable to communicate or has cognitive or emotional limitations that negatively impact their communication or decision-making ability, the case manager may determine that the customer does not have the capacity to self-direct their services. This determination is typically supported from case documentation which can be obtained from a number of sources, including but not limited to: medical reports, psychological and neuropsychological evaluations, case manager observations, documented instances showing the inability to properly manage a personal assistant, information from the customer's family and/or representative, and failure to pass the Mini-Mental Status Examination on the DON. If it is determined that a customer cannot self-direct, the case manager will identify a legal guardian, power of attorney, or other individual to represent the customer and to assist with the assessment and service planning process.

The state looks at many factors when assessing the ability to self-direct. Some examples include:

1. History of behavioral problems; A history of behavioral, emotional, and/or cognitive impairments can be determined by obtaining clinical documentation of serious mental impairments that limits the customer's psychological function. For example, a clinical recommendation for 24/7 care due to a customer's inability to be left alone due to severe impulsivity could be included as evidence of a behavioral problem. Review of this information as well as other factors will determine whether or not this person may benefit from ongoing case management services.

2. Ongoing treatment for mental health concerns: Customers who are receiving ongoing treatment for psychological impairments from a mental health provider may be considered in need of ongoing case management services. Clinical documentation should be obtained and reviewed in order to determine the degree of risk experienced by the customer. This information will be reviewed by the case manager to determine the impact on self-direction.

3. Difficulty maintaining providers: Evidence that a customer is unable to consistently maintain service providers is a possible indicator that the customer may have difficulty self-directing. The case manager would monitor this activity and make recommendations such as the need to change the provider type to an agency provider.

4. A history of poor judgment or decision-making: Customers who have a history of making poor choices due to severe behavioral or cognitive limitations may have difficulty self-directing. Evidence of this history should include documentation that the customer is unable to exercise good judgment and/or has participated in behaviors that present a risk to self or others. Additional information could include direct observation of this behavior by the case manager,

provider, or from other individuals. Services provided by a personal assistant will only be provided when it has been determined by the case manager that the customer has the ability to supervise the personal care provider. In cases where the case manager determines that: the personal assistant cannot meet the needs in the care plan, the customer cannot manage a personal assistant, or the customer's health or safety is at risk, the case manager will acquire homemaker services through an agency provider. These services will be provided in accordance with the plan of care.

For participants enrolled in an MCO, the Plan care coordinator will provide the necessary supports to assure continuity of services and participant health and welfare during the transition.

Services provided by a personal assistant will only be provided when it has been determined by the Plan's case manager that the participant has the ability to supervise the personal care provider.

In cases where the Plan's case manager determines that the personal assistant cannot meet the needs of the member outlined in the service plan, or the participant cannot manage a personal assistant (and if the participant has no reliable person available to assist in managing the personal assistant), or the participant's health or safety is at risk by continuing to use a personal assistant, the Plan case manager will consider the need to terminate the participate directed service involuntarily.

Prior to terminating any participant directed service the Plan case manager will send the participant a Notice of Action that provides the member with information as to why their service is being terminated or reduced and includes their rights to appeal and fair hearing process.

The Plan case manager will replace the participant directed service with comparable agency directed services and do so timely to prevent a gap in service or care. Participants maintain the right to choose an agency provider in the Plan's contracted provider network. The service plan will be updated to reflect any changes.

The MCOs have received initial and ongoing training from the OA regarding participant direction and oversight of personal assistants. The OA has shared their provider standards with the MCOs that include information on how to determine if the PA can meet the customer's needs. The OA also provides guidance on how to determine when a PA is not meeting needs and when it is appropriate to change from a PA to a homemaker provider. The MA and OA do not specifically monitor the decisions that are made by the MCO.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	1184	
Year 2	1222	
Year 3	1261	
Year 4	1299	
Year 5	1338	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in*

Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

The co-employer is the State of Illinois, Division of Rehabilitation Services.

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

If a participant requests a that a criminal background check be completed, the OA obtains the criminal background check on behalf of the participant and the State pays all associated costs of acquiring the background check.

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☐ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☐ **Reallocate funds among services included in the budget**

☐ **Determine the amount paid for services within the state's established limits**

☐ **Substitute service providers**

☐ **Schedule the provision of services**

☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☐ **Identify service providers and refer for provider enrollment**

☐ **Authorize payment for waiver goods and services**

☐ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

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.

Eligible individuals (or their parent or legal guardian) will be informed of the feasible alternatives available under the waiver at the time they make application for waiver services. The Choice form is explained to the individual and alternative providers in the area presented in order for the individual to make an informed choice between waiver and institutional services. Individuals may consider other potential providers with visits arranged by the OA AIDS case manager before they choose services.

The fair hearing process is explained to the individual or legal guardian at the time of initial application, upon redetermination for the program, and upon any change in services with which the client does not agree. Rules for fair hearings are found at 89 Il. Adm. Code, Part 510, Appeals and Hearings, and are summarized throughout this section. The Medicaid agency is the final level of appeal.

Notice will be provided to the participant by the OA AIDS case manager for each of the following adverse actions. HSP services, and therefore waiver services, shall be denied or terminated and case closure initiated at any time the participant:

-Refuses services or further services;
-Moves from the State of Illinois or cannot be located or contacted;
-Dies;
-Is institutionalized and not expected to be released for a period to exceed 60 calendar days;
-Is determined to have a projected service cost above that of the projected cost of institutionalization, with the exceptions found at 89 Il. Adm. Code 682.500(a), 682.520, and 684.70(c);
-Has been referred to another agency for the same or similar services and no longer requires or is eligible for HSP services;
-Fails to conduct himself/herself in an appropriate manner (e.g., physical, sexual or repeated verbal abuse by a participant against a DHS employee, provider or agent providing services through OA; knowingly providers false information; or performs illegal activity that would directly and adversely affect the OA);
-Is not, or is no longer, at risk of institutionalization due to improvement of his/her condition;
-Fails to meet other eligibility criteria as found at 89 Il. Adm. Code 682 as a result of an initial determination of eligibility or redetermination of eligibility. Previously, there was a requirement for physician's approval. As explained in more detail in Appendix B-2-b, the OA is working to eliminate the physician certification requirement in Section 682.100(g).
-Fails to cooperate (e.g., refuses to complete and sign necessary forms, fails to keep appointments, fails to maintain adequate providers) or
-Cannot have a safe and adequate service plan developed for him/her as a result of the original determination of eligibility or redetermination of eligibility. Previously, there was a requirement for physician's approval. As explained in more detail in Appendix B-2-b, the OA is working to eliminate the physician certification requirement in Section 682.100(g).

When an AIDS case manager makes an adverse case decision, the participant will receive a service notice that explains the decision and informs the participant of his/her right to appeal. The service notice is sent to the participant at least 15 days prior to the effective date of the action. The counselor is responsible to notify the participant immediately after the decision. If the participant desires assistance during the hearing, he/she may request such assistance from the DHS Client Assistance Program (CAP). Personnel within the CAP program are impartial advocates who assist the participant during the appeal process. The service notice indicates that services will continue until after the hearing office renders a decision. A copy of the service notice is retained in the case file. When available, a copy of the request for appeal may also be in the service file, and will always be maintained in the appeal file under the DHS Division of Hearings and Appeals.

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 Medicaid agency’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).

MCOs inform Enrollees about the Medicaid agency’s fair hearing process in the member handbook distributed at the time of enrollment. Information about the fair hearing process is also on the MCOs website on an ongoing basis and is provided whenever an Enrollee requests the information. 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.

An Enrollee or an authorized representative with the Enrollee’s 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.

A summary of all appeals filed by Enrollees and the responses and disposition of those matters (including decisions made following an external independent review) must be submitted to the Medicaid agency quarterly. Records of adverse actions and requests for appeals are maintained by the MCOs for a period of six (6) years.

1) The State ensures that managed care enrollees 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.

2) 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.

The Plans have a separate appeal process that occurs prior to the Fair Hearing process. 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.

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.

Prior to scheduling a hearing, the participant may be offered the opportunity to participate in an informal resolution conference. The primary goal of this exercise is to attempt to reach mutual resolution of the issues being appealed. Participants may request an Informal Resolution Conference, in the period between the filing of the appeal and the hearing decision, by contacting the office out of which they receive services. Participant's Guidance on Rights/Responsibilities/Appeals Procedures; Section 510.100 Informal Resolution Conference).

An informal resolution conference is offered to the participant at the time an appeal is filed. This process is not a pre-requisite but is a conflict resolution option that is offered to the participant prior to a formal hearing. The intent of the conference is to mutually resolve issues being appealed. Once the OA field office is aware that an appeal has been filed, the participant is contacted and advised of the availability of the informal resolution conference. If the participant so requests, the conference is held at a time and date convenient to all parties. The conference is typically held at the OA office but can be held at the participant's home if they are unable to attend at the office. The OA office supervisor schedules and chairs the conference. Also in attendance are the counselor who made the decision in question, as well as any other parties or participant representatives as required.

The informal resolution conference is concluded either with a mutually agreed-upon resolution of the issue or some of the issues, or with the conclusion that the issues cannot be resolved and the appeal should proceed to hearing. If satisfactorily resolved, the participant formally withdraws the appeal by contacting the OA hearings administration office

Informal resolution offers an opportunity to resolve differences prior to going to hearing. This may take the place of the hearing, if all parties agree on the resolution, but is not required. This is offered as another mechanism through which to address participant's concerns. If the issue cannot be resolved, then the case proceeds to the hearing level. Informal resolution is conducted by the OA AIDS Administration Unit manager, and includes the case manager and participant, and other individuals, as required although ordinarily this is kept as informal as possible. If the issues under appeal are resolved according to the satisfaction of all parties, the participant's services will reflect this, the participant will withdraw the appeal, and the DHS Bureau of Hearings will close the appeal file.

DHS Bureau of Hearings utilizes impartial hearing officers who schedule hearings at a reasonable date and time for all parties. At least three days prior to the hearing, information submitted by each participant is forwarded to all parties. The hearing officer conducts the hearing, and afterwards renders a decision within 90 days following the hearing. The final administrative decision is made by the Medicaid agency.

Participants who are terminated from the waiver due to extended institutional stay are allowed to re-enroll in the waiver upon discharge, should the participants desire to re-enroll. Appeals must be received within 30 calendar days after the date the grievant receives the notice or 35 calendar days after the date of the post mark on the notice, if the customer was informed by mail, whichever is later.

FFS participants 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.

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, outcome, incident summary, resolution summary, and dates. The 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: Nursing Facility Services; HCBS Waiver for Persons who are Elderly; HCBS Waiver for Assisted Living, Supportive Living Program; Persons with Physical Disabilities Waiver; Persons with HIV/AIDS Waiver; and Persons with Brain Injury 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.

The State reviews/approves the MCO's appeal process guidelines.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The Department of Human Services, Division of Rehabilitation Services is responsible for operating the grievance/complaint system. This system is discussed in section F-1: Opportunity to Request a Fair Hearing.

For participants enrolled in an MCO, the Plans shall establish 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 Department through the Fair Hearing process. Enrollees must exhaust the MCO's Grievance process before requesting a Fair Hearing.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) The OA, DHS Division of Rehabilitation Services, is responsible for ensuring that all Unusual Incident Reports (UIR) are processed in a timely and appropriate manner. Immediately upon receipt of an unusual incident report, it is shared with the designated unit within the OA that is responsible for coordinating these investigations. UIR Unit staff determine whether the incident includes abuse, neglect, or financial exploitation, and if so, the respective OIG is immediately contacted. Additionally, it is determined whether immediate agency action is required. If so, OA case management staff are provided with specific instructions on any actions to pursue. Any direction received from the respective DHS Office of Inspector General is also acted on immediately. Throughout this process, UIR Unit staff work directly with the manager of the HIV/AIDS program, as well as case management personnel in order to ensure proper resolution. As a result, a high level of interaction is maintained on an ongoing basis by administrative and field staff.

(b)An unusual incidents database is maintained by the OA, and is monitored on an ongoing basis. Data are reviewed for analysis to determine if there are any trends or issues requiring further investigation. Results of this review will be shared with the MA administration at least annually. Any trends and/or patterns determined from data analysis will be addressed by the OA and MA as needed or during quality management meetings. Upon receipt of a grievance or complaint, the case manager immediately completes an unusual incident report that is disseminated to appropriate OA administrative personnel. Again, if the issue concerns possible abuse and neglect, DHS-OIG is notified as well.

(c)Case managers are required to contact participants at least once per month to check the health, safety and welfare of the participant and follow-up on any identified issues. At that time the case managers also review the services received and determine if any additional services are needed.

The participant is informed that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing. Fair hearings result from appeals filed by the participant for adverse decisions that have been rendered by the case manager. For instances in which the case manager is accused of misconduct, then an unusual incident (complaint) report would be filed and the participant would also have the option of filing an appeal - if the conduct resulted in an adverse case decision.

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 informal system, available internally, to attempt to resolve all grievances;
•A formally structured Grievance system that is compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 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 formally structured Grievance Committee that is available for Enrollees whose Grievances cannot be handled informally and are not appropriate for the procedures set up under the Managed Care Reform and Patient Rights Act. All Enrollees must be informed that such a process exists. Grievances at this stage must be in writing and sent to the Grievance Committee for review;
•The Grievance Committee must have at least one (1) 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 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 process before accessing the Fair Hearings process. Enrollees are notified of this through the Enrollee Handbook, the Notice of Action, and any appeal letters. Plans also discuss the grievance and appeals process with the Enrollee 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).

Critical Event Reporting System

The OA has developed, and is in the process of implementing, procedures and reporting strategies to track critical incidents including unusual incidents reports (UIRs) and allegations of abuse, neglect, and exploitation (ANE) for participants in the three HCBS waivers operated under the HSP, including persons with HIV/AIDS. Preliminary reports are being received through the WebCM, and all critical events are being reviewed. The OA Central Office is being alerted to situations requiring immediate action or follow-up. Remediation is being handled on an individual basis.

At a minimum abuse, neglect and exploitation must be reported. Other examples of critical events may include but are not limited to:
• Death
• Suspicious death
• Falls
• Serious physical injury
• Hospital admission
• 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
• Suicide or attempted suicide

The final systems database is projected to be completed by the effective date of the waiver renewal. The systems database will allow the OA to do comprehensive analysis of event reporting and resolution. The OA will begin sharing reports with the MA on a quarterly and annual basis as evidence of compliance and to determine the need for systems improvement strategies.

Case managers are required to contact participants once per month to check the health, safety and welfare of the participant and follow-up on any identified issues. If AIDS case managers are made aware of the incidents, they report the incident to the DHS-DRS, the operating agency (OA), central office. Case management staff are assigned to the cases. Staff assist with reporting and remain involved in the case to ensure the participant is safe from harm and that an adequate plan of care is in place.

Allegations of Abuse, Neglect and Exploitation

Participants under the age of 18

The Abused and Neglected Child Reporting Act - ANCRA (325 ILCS 5) sets forth the requirements for reporting and responding to situations of abuse and neglect against children under the age of eighteen.

The types of critical incidents that must be reported include any specific incident of abuse or neglect or a specific set of circumstances involving suspected abuse or neglect, where there is demonstrated harm to the child or a substantial risk of physical or sexual injury to the child. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child’s welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

Although anyone may make a report, mandated reporters are professionals who may work with children in the course of their professional duties. There are seven groups of mandated reporters defined in the Abused and Neglected Child Reporting Act - ANCRA (325 ILCS 5/4). They include: medical personnel, school personnel, social service/mental health personnel (including staff of both the Waiver Medicaid Agency and the Waiver Operating Agency), law enforcement personnel, coroner/medical examiner personnel, child care personnel (including all staff at overnight, day

care, pre-school or nursery school facilities, recreational program personnel, foster parents), and members of the clergy.

Mandated reporters are required to report suspected child maltreatment immediately when they have reasonable cause to believe that a child known to them in their professional or official capacity may be an abused or neglected child. This is done by calling the Department of Children and Family Services 24-hour hotline (800-25-ABUSE). Reports must be confirmed in writing to the local investigation unit within 48 hours of the hotline call.

DCFS Hotline Numbers:
1-800-25-ABUSE or 1-800-252-2873 (voice)
1-800358-5117 (TTY)

Participants aged 18 through 59:

For participants ages 18 through 59, the State is implementing changes related to the State Authority for reporting and investigating abuse, neglect, and exploitation (ANE). The Illinois legislature has proposed legislation to consolidate this function under a single entity for all eligible adults ages 18 and older. The Department on Aging will have the authority to receive reports and investigate ANE, expanding their current system for Elder Abuse. See sction below on Adult Protective Services Act
for more details.

Currently, the operating agency (DHS) Office of the Inspector General (OIG), which is a semi-independent entity that reports to both the Governor and the Secretary of DHS, investigates alleged abuse, neglect and exploitation of adults with mental, developmental, or physical disabilities in private homes and of adults with mental or developmental disabilities in DHS-funded community agencies.

The DHS Office of Inspector General Adults with Disabilities Domestic Abuse Intervention Act has statutory authority to respond to allegations related to adults with disabilities between the ages of eighteen and fifty-nine who reside in domestic situations. OIG has authority to investigate, take emergency action, work with local law enforcement authorities, obtain financial and medical records, and pursue guardianship. With the individual's consent, substantiated cases are referred to DHS for development of a service plan to meet identified needs.

OIG Hotline Number: 1-800-368-1463 (voice and TTY)

Participants 60 years of age or older

Persons can report suspected abuse, neglect or exploitation to Department of Aging (DoA) by utilizing the Elder Abuse Hotline number at 1-866-800-1409, available 24 hours a day, seven days a week, or to the Senior Help Line number, 1-800-252-8966, during regular business hours. After-hour and weekend calls are automatically transferred to the Elder Abuse Hotline number.

Adult Protective Services Act

The State has proposed legislation to consolidate to a single entity the reporting and investigation of abuse, neglect, financial exploitation (ANE), or self-neglect of eligible adults ages 18 and older. The Department on Aging will have the authority to receive reports and investigate ANE, expanding their current system. The Act will amend the Elder Abuse and Neglect Act and various Acts to change references to the short title - Adult Protective Services Act. The Act will repeal the Abuse of Adults with Disabilities Intervention Act above that is currently in place and therefore, the DHS OIG authority to respond. The DoA will establish by rule mandatory standards for the investigations and mandatory procedures for linking eligible adults to appropriate services and supports.

Along with the above, the Act provides that the DoA:
•Establish a centralized Adult Protective Services Helpline for the purposes of reporting the ANE that is accessible 24 hours a day, 7 days a week and to post its telephone number online.
•Establish of a Statewide Fatality Review Team; and other matters. Effective July 1, 2013.

Certain activities are slated to be implemented upon the effective date of the Act, and others as is practical.

Managed Care

For participants enrolled in an MCO, the Plans will have processes and procedures in place to receive reports of critical incidents. The Plans shall comply with the requirements in State statute for reporting abuse, neglect or exploitation to the investigative authority. The Plan shall have a formal process for reporting incidents that may indicate abuse, neglect or exploitation of an Enrollee.

The Plans must comply with the OA's critical incident reporting requirements as listed above. For these types of incidents, if there is a perceived immediate threat to a member's life or safety, the Plan will follow emergency procedures which may include calling 911.

All incidents will be reported to the compliance officer or designee and entered in to the Plans Critical Incidents report database. Based on situation, the members age and placement reports will also be made to the appropriate State of Illinois investigative agencies.

The Plans will continue to provide the 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 will assure that HCBS waiver agencies, vendors and workers (including case managers) are well informed of their responsibilities to identify and report all critical incidents. Responsibilities are also reinforced through periodic training.

IDoA will share all substantiated findings of abuse, neglect, and exploitation with the OA and the MA. When appropriate, IDoA will share recommendations for follow-up with the OA and the MA. This will occur on a real-time ongoing basis as investigations are completed and final determinations are made. The MA will work with the OA and the Managed Care Plans to assure that findings are tracked and recommendations are implemented.

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.

Upon initial eligibility determination, and subsequent re-determination of eligibility, customers are informed of their rights and responsibilities, including their right to be free from abuse, neglect, and exploitation. Information is shared on whom to notify if abuse, neglect or exploitation occurs. All waiver participants must review and sign Home Services Program Application and Redetermination of Eligibility Agreement. The contents of this document are thoroughly explained the customer. In addition, participants are contacted once per month by case management staff in an effort to ensure that services are being provided in a safe and appropriate manner. (Section 677.10 Assurance of Customer Rights)

For participants enrolled in an MCO, the Plan shall train all of Plan's employees, Affiliated Providers, Affiliates and subcontractors to recognize potential concerns related to Abuse and Neglect, and on their responsibility to report suspected or alleged Abuse or Neglect. The 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 will be trained about the signs of Abuse and Neglect, what to do if they suspect Abuse or Neglect, and the Plans responsibilities. Training sessions will be customized to the target audience. Training will include general indicators of Abuse and Neglect and the timeframe requirements for reporting suspected Abuse, Neglect and exploitation.

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.

Abuse, Neglect and Exploitation
For participants under the age of 18:
The Department of Children and Family Services (DCFS) is the state agency that is responsible for conducting investigations of child maltreatment and arranging for needed services or protective plan as appropriate, for children and families where credible evidence of abuse or neglect exists (indicated cases). DCFS provides protective services at the request of the subjects of the report, even when the report has been unfounded.
DCFS field office staff are required to make initial contact and start the investigation of the allegation within 24 hours of the hotline report. If there is a possibility that the family may flee or if the immediate well being of the child is endangered, an investigation will start immediately.
Most investigations are conducted in 60 days unless there is just cause for a 30 day extension to make a determination whether the allegation is indicated or unfounded. Appropriate emergency services are provided while the investigation is pending. Emergency and ongoing services may include safety plans, protective plans, family support or protective custody, which places the child in substitute care.
Serious allegations such as sexual abuse, serious physical harm, or death are reported to the local law enforcement agency, the State's Attorney, and to the Child Advocacy Center, if available, as a coordinated approach to the investigation. The approach includes victim sensitive interviewing of the alleged child victim(s) and identification and prosecution for a criminal act. DCFS uses a Child Endangerment Risk Assessment Protocol (CERAP) to assess safety of the child. The interview process includes an assessment of the alleged victim's immediate safety. Safety plans can include voluntary removal of the alleged perpetrator or of the alleged victim. If the family refuses to establish a safety plan to control for the threats of danger to the alleged victims, then the child is removed. DCFS staff conduct face-to-face monitoring and reassessment every five days until the child is determined to be safe in the home.
A protective plan is enforced in out-of-home settings, such as daycares and residential settings. The protective plan restricts accessibility of the perpetrator to the child, and it stays in place until the investigation is completed. If the investigation determines that an abuse or neglect situation is indicated, license revocation or remediation activities begin. Monitoring is conducted weekly by investigators and licensing staff until resolved.
If a finding is indicated, the perpetrator's name is placed on the DCFS State Central Register for a minimum of five years, 20 years if there was serious physical injury, and 50 years in cases of sexual penetration or death. If a finding is unfounded, the name is on the DCFS State Central Register for a minimum of 30 days up to three years depending on the seriousness of the situation.
Participants Age 18 through 59:
For participants ages 18 through 59, the State is implementing changes related to the State Authority for reporting and investigating abuse, neglect, and exploitation (ANE). The Illinois legislature has proposed legislation to consolidate this function under a single entity for all eligible adults ages 18 and older. The Department on Aging will have the authority to receive reports and investigate ANE, expanding their current system for Elder Abuse. See sction below on Adult Protective Services Act
for more details.
Currently, the Department of Human Services (DHS), Office of Inspector General (OIG), a semi-independent entity that reports to both the Governor and the OA, has statutory authority under Abuse of Adults with Disabilities Intervention Act, 59 Il. Admin. Code 51, to respond to allegations related to adults with disabilities ages of 18 through 59 who reside in domestic situations. Under the statute, DHS OIG has authority to investigate, take emergency action, work with local law enforcement authorities, obtain financial and medical records, and pursue guardianship.
The DHS OIG initiates an assessment of all reports of alleged or suspected abuse or neglect within seven calendar days after the report. Reports of abuse or neglect that indicate that the life or safety of an adult with disabilities is in imminent danger are to be assessed within 24 hours after the receipt of the report. Reports of exploitation are to be assessed within 30 calendar days after receipt of the report. When the OA determines that a case is substantiated, it is referred to the appropriate office within the DHS to develop, with the consent of and in consultation with the adult with disabilities, a service plan for the adult with disabilities.
Investigations for critical incidents begin as soon as they are received by the OA state office, but processes and timeframes vary depending on the type of incident that occurs. Once the critical incident has been reviewed and resolved by the OA state office, the local OA office is notified about the result and recommendations. The counselor, office supervisor and regional assistant bureau chief are contacted immediately at the conclusion of the investigation. Once notified, the field office is instructed to immediately contact the participant/authorized person, if further action is required. For example, if the incident involved fraudulent activity of a provider, the participant would be notified of action taken against the provider. Assistance would be offered to the participant to secure a replacement provider. Other incidents such as fraud or abuse and neglect are forwarded to other investigating bodies and it is up to those entities to follow up on the investigation results. The OA may be instructed to contact the participant, which is completed immediately. Once contact is made and/or any actions taken in response to the investigation, the OA field office must

notify OA state office within two business days that the follow up has occurred.
The OA, DHS-DRS, is responsible to ensure that all services provided to participants are safe and adequate and is responsible for ensuring that all reports of unusual incidents (UIR) are processed in a timely and appropriate manner.
Participants Age 60 and Older:
The Department on Aging (DoA) Office of Elder Rights 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. The program is locally coordinated through 41 provider agencies designated by the Area Agencies on Aging (AAA) and the DoA.
When a call is received alleging abuse, neglect or exploitation of an elderly person, intervention occurs within 24 hours, 72 hours or seven days, depending on the priority assigned to the nature of the allegation. Face-to-face visits are made within 24 hours of situations that are deemed life threatening or pose severe risks. The Elder Abuse Agencies work with older adults in resolving abusive situations.
Adult Protective Services Act
The State has proposed legislation to consolidate to a single entity the reporting and investigation of abuse, neglect, financial exploitation (ANE), or self-neglect of eligible adults ages 18 and older. The Department on Aging will have the authority to receive reports and investigate ANE, expanding their current system. The Act will amend the Elder Abuse and Neglect Act and various Acts to change references to the short title - Adult Protective Services Act. The Act will repeal the Abuse of Adults with Disabilities Intervention Act above that is currently in place and therefore, the DHS OIG authority to respond. The DoA will establish by rule mandatory standards for the investigations and mandatory procedures for linking eligible adults to appropriate services and supports.
Certain activities are slated to be implemented upon the effective date of the Act, and others as is practical.
The DoA will use the same program model for responding to allegations of abuse of adults with disabilities, ages 18 through 59, as described above being is used for persons age 60 and older. The Elder Abuse Agencies will continue to work with older adults, age 60 and over, in resolving abusive situations. DoA is working with other State agencies to establish protocols for linkage to appropriate services and supports for persons ages 18 through 59.
For participants enrolled in an MCO, the Plans will have processes and procedures in place to receive reports of critical incidents. Critical events and incidents must be reported and identified issues routed to the appropriate department within the Plan and when indicated to the investigating authority described above. The procedures will include processes for ensuring participant safety while the State authority conducts its investigation.

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.

Immediately upon receipt of an unusual incident report, DHS-DRS, the operating agency (OA) submits the report to the designated UIR Unit within DRS. The UIR Unit staff determine whether the incident includes abuse, neglect, or financial exploitation, and if so, the respective investigating authority is immediately contacted. Additionally, it is determined whether immediate action is required by the OA. Any direction received from the DHS Office of Inspector General, or other investigative authority, is acted on immediately.

UIR Unit staff work with the manager of the AIDS Administrative Unit as well as case managers to ensure proper resolution. Unusual incidents are monitored by the OA administration on an ongoing basis. Data are reviewed for analysis, and to determine if there are any trends or issues requiring further investigation.

If the State ANE Authority determines that a case is substantiated, it is referred to the appropriate office within the OA or the MCO to develop, with the consent of and in consultation with the adult with disabilities, a service plan to address the person's needs.

In the current system, the DHS Abuse, Neglect, and Financial Exploitation (A/N/E) investigator contacts appropriate field personnel to request follow up on an allegation and/or an update on attempts to resolve the situation. Field personnel indicate whether or not an internal investigative review has been completed and the results of that review; and whether external agencies were contacted for assistance such as the Office of Inspector General, the local police, the DHS Divisions of Mental Health or Developmental Disabilities, etc. All information gathered from these sources is entered into the DHS incident investigation file. Similar processes are being developed in anticipation of the implementation of the Adult Protective Services Act, decribed below.

Unusual incident reports as submitted by the field and intake and final reports from the DHS-OIG are entered into the DHS-DRS unusual incident database. This information is confidential, and is retained for monitoring purposes. The data are reviewed to determine if there are trends or patterns, and if there are situations that need additional investigation or follow up. When warranted, further investigation is pursued. Information stored in the database helps to prevent recurrence of incidents involving the same customer and an alleged offender.

Once completed the systems database for OA Critical Event Reporting System will allow more comprehensive analysis of event reporting and resolution.

Adult Protective Services Act

The State has proposed legislation to consolidate to a single entity the reporting and investigation of abuse, neglect, financial exploitation (ANE), or self-neglect of eligible adults ages 18 and older. The Department on Aging will have the authority to receive reports and investigate ANE, expanding their current system. The Act will repeal the Abuse of Adults with Disabilities Intervention Act above that is currently in place and therefore, the DHS OIG authority to respond. The DoA will establish by rule mandatory standards for the investigations and mandatory procedures for linking eligible adults to appropriate services and supports.

Certain activities are slated to be implemented upon the effective date of the Act, and others as is practical.

The Elder Abuse Agencies will continue to work with older adults, age 60 and over, in resolving abusive situations. DoA is working with other State agencies to establish protocols for linkage to appropriate services and supports for persons ages 18 through 59.

For participants enrolled in an MCO, the Plans will maintain an internal reporting system for tracking the reporting and response to critical incidents, and analysis of the event to determine whether individual or systemic changes are needed. Critical incident reporting will be included in the reporting requirements to the 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:

The State does not authorize the use of restraint or seclusion in the waiver program. Any allegations of restraint, seclusion, or other potential abuse, neglect, or financial exploitation would be reported to administration via the unusual incident report procedure. Simultaneously, an alleged incident would be reported to the proper authority for review. (See Appendix G-1 for information about critical event or incident reporting requirements.)

For participants enrolled in an MCO, the Plans are responsible to detect the unauthorized use of restraint or seclusion. Events involving the use of restraint or seclusion would be reported to the Plan as a reportable incident, and reported to the investigating authority as indicated.

The OA rehabilitation counselor as well as the managed care – care coordinator ensures that restrictive interventions have not been forced on the participant. Staff monitors conditions in the home when completing eligibility determinations and service planning. The participant is asked if there have been incidents of abuse, neglect, or financial exploitation. If this is affirmed, the rehabilitation counselor or care coordinator will file a report with Adult Protective Services, which is obligated to investigate such allegations.

a. Likewise, if the participant or another individual contacts the OA or MA and reports that restraints or other restrictive interventions have been forced on the participant, a report will be filed with Adult Protective Services (APS) for investigation. APS will notify the OA of the outcome of the investigation. The OA and MA will follow recommendations as provided by APS.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The State does not authorize the use of restraint or seclusion in the waiver program. Any allegations of restraint, seclusion, or other potential abuse, neglect, or financial exploitation would be reported to administration via the Unusual Incident Report procedure. Simultaneously, an alleged incident would be reported to the proper authority for review: the Department of Children and Family Services; the Office of Inspector General; or the Department on Aging. (See Appendix G-1 for information about critical event or incident reporting requirements.)

For participants enrolled in an MCO, the Plans are responsible to detect the unauthorized use of restrictive interventions. Events involving the use of restraint or seclusion 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:

Any allegations of restraint, seclusion, or other potential abuse, neglect, or financial exploitation would be reported to administration via the unusual incident report procedure. Simultaneously, an alleged incident would be reported to the proper authority for review. (See Appendix G-1 for information about critical event or incident reporting requirements.)

For participants enrolled in an MCO, the Plans are responsible to detect the unauthorized use of restraint or seclusion. Events involving the use of restraint or seclusion would be reported to the Plan as a reportable incident, and reported to the investigating authority as indicated.

○ **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 States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
41G: # and % of participants' substantiated incidents that were reported by the Investigative Authority to the OA and MCO and resolved within recommended timelines.N: # of substantiated incidents reported to the OA and MCO that were resolved within recommended timelines. D: Total # of substantiated incidents reported to the OA and MCO.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: OIG Report (via unusual incident data base)

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

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:
47G: # and % of OA and MCO participants who have personal assistant or other independently employed services whose service plan included back up plans. N:# of

OA and MCO partcpts revwd who have personal assistant or other independently employed services whose service plan included back up plans. D: Total OA and MCO partcpts revwd who have personal assistant or other independently employed srvcs.

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 = +/-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:
OA Reports: HSP QA Audit Reports

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

collection/generation *(check each that applies):*	*(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/-5%
☐ **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**

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

Performance Measure:
46G: # and % of participants for whom identified critical incidents other than A/N/E were revwd and corrective measures were appropriately taken by the OA and MCO. N: # of partcpts for whom identified critical incidents other than A/N/E were revwd and corrective measures were appropriately taken by the OA and MCO. D: Total # of OA and MCO partcpts for whom identified critical incidents were revwd.

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:
OA Reports: OIG Report (via unusual incident data base)

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:
43G: # and % of participant deaths as a result of a substantiated case of abuse, neglect or exploitation where appropriate follow-up actions were implemented by the OA and 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 OA and MCO. D: Total # of OA and MCO deaths as a result of a substantiated case of A/N/E.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: OIG Report (via unusual incident data base)

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

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:
44G: # and % of restraint applications, seclusion or other restrictive interventions where appropriate intervention by the OA and MCO occurred. N: # of restraint applications, seclusion or other restrictive interventions where appropriate intervention by the OA and MCO occurred. D: Total # of OA and MCO restraint applications, seclusion or other restrictive interventions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: OIG Report (via unusual incident data base)

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 =
☐ **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

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:
42G: # and % of participant substantiated cases of abuse, neglect or exploitation received from the Investigative Authority where the OA and MCO implemented the recommendations. N: # of substantiated cases of A/N/E received where the OA and MCO implemented the recommendations. D: Total # of substantiated cases of abuse, neglect or exploitation received by the OA and MCO.

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:
OA Reports: OIG Report (via unusual incident data base)

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

Data Aggregation and Analysis:

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

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

Performance Measure:
45G: # and % of participant survey respondents who reported to the OA and MCO of being treated well by direct support staff. N: # of participant survey respondents who reported to the OA and MCO of being treated well by direct support staff. D: Total # of OA and MCO participant survey respondents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: QA Satisfaction Surveys: POSM Survey question E.1.a

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:

		10% of the population selected randomly by region
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports: POSM Survey question E.1.a

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:
40G: # and % of participants who received information from the OA and MCO about how and to whom to report abuse, neglect, exploitation at the time of assessment/reassessment. N:# of partcpt records reviewed where the partcpt recvd info from the OA and MCO about how and to whom to report abuse, neglect exploitation at the time of assessment/reassessment. D: Total # of OA and MCO partcpt recs revwd.

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 Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: HSP QA Audit 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**	☒ **Annually**	☐ **Stratified**

Specify:		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:
48G- # and % of HSP Individual Provider (Personal Assistant) evaluations returned reporting satisfaction as stated in the approved waiver. N: # of HSP Individual Provider (PA) evaluations completed that report satisfaction as stated in the approved waiver. D: Total # of Individual Provider (PA) evaluations completed.

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

Data Aggregation and Analysis:

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

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

Performance Measure:
49G- # and % of participants who received information from the OA and MCO regarding universal precautions. N: # of participants records reviewed where there is a signed document that shows the participant received information from the OA and MCO about universal precautions. D: Total # of OA and MCO participant records reviewed.

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

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.

The Medicaid agency, MA, 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 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 will pull 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 will be summarized by the Plans and reported at least quarterly to the MA. For those functions delegated to the MCO, the MA is responsible for discovery.

In the MA's contracts with Integrated Care Program 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.

As part of the MA's quality oversight and monitoring of the waiver providers, the EQRO will perform quarterly onsite audits of the enrollee care plans through chart validation. This information will be submitted to the MA for review and analysis.

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.

b. Methods for Remediation/Fixing Individual Problems

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

the methods used by the state to document these items.

40G:The OA/MCO will assure that participants know how to report abuse, neglect or exploitation. This will be demonstrated by correction of case work documentation reflecting participant awareness, including evidence of steps taken to educate the participant. Remediation must be completed within 30 days.

41G:The OA/MCO will follow up all outstanding substantiated referrals and Unusual Incident Reports. Changes in participants' service plans will be made when needed. Remediation must be completed within 30 days.

42G:The OA/MCO will implement the investigative authority recommendations for substantiated cases of abuse, neglect or exploitation. Changes in participants' service plans will be made when needed. Remediation must be completed within 30 days.

43G:The cause of death/circumstances would be reviewed by the OA and 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.

44G:Restraint applications, seclusion, or other restrictive interventions will be reviewed by the OA and 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.

45G:If identifying information is available for individual surveys 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.

46G:The OA and 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.

47G:The OA and MCO would develop and implement PA back up plans and revisions to customers' service plans. Timeline for remediation would be 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:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may

provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency (MA), and the Illinois Department of Human Services, Division of Rehabilitation Services (DHS-DRS), as the Operating Agency (OA), and the contracted Managed Care Organizations (MCOs) will work in partnership to evaluate the waiver Quality Management System (QMS) and to analyze the information derived from discovery and remediation activities for each of the federal assurances.

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 are 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.

The persons with HIV/AIDS waiver Quality Management System (QMS) plan is part of an overall quality management plan for the three 1915 (c) waivers operated by the DHS-DRS (OA). The other waivers include the Persons with Disabilities Waiver (control number IL.0142), and the Brain Injury Waiver(control number IL.0329). While some data may be collected during the same on-site provider and case manager reviews, the sample for each waiver is drawn separately and the results are aggregated separately.

On a quarterly basis, the MA will conduct 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 to be collected semi-annually or annually will be 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 will be produced identifying trends based on the full representative sample and/or 100% review of data.

OA and MCO data will be reported by individual performance measures. The OA will also report on findings from the other two waivers under its umbrella, for comparison purposes. Individual performance measure reports will include: level of compliance and timeliness of remediation based on immediate, 30, 60, 90 day increments and any outstanding remediation. The MCOs will report in the same format as the OA.

During quarterly meetings, the MA and the OA or MCO will 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 will be discussed and analyzed regarding cause, contributing factors and opportunities for system improvement. Systems improvement will be 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 will maintain separate QMC Systems Improvement Logs. Recommendations for system improvements will be added to the log(s) for tracking purposes. The OA and the MCOs will document the systems improvement implementation activities on its respective log. The MA will assure that the recommendations are followed through to completion. Decisions and time lines for system improvement will be made based on consensus of priority and specific steps needed to accomplish change. These decisions will be documented on the systems improvement log and will be communicated through the sharing of the quarterly meeting summary and the systems improvement log.

ii. System Improvement Activities

Responsible Party*(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**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **Other** Specify: MCO	☐ **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.

The processes Illinois follows to continuously evaluate, as appropriate, effectiveness of the QMS are the same as the 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. Meeting with all parties annually will provide an arena to see the system holistically and determine how well the system design changes are working and what areas need further improvement. Decisions that are made as a result of these meetings will be tracked on the QMC Systems Improvement Log.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

One QMC meeting a year will be a combined meeting where the MA, the OA, and the MCOs will meet and discuss statewide issues impacting the waiver. During this annual meeting, the OA and the MCOs will provide an overview of the previous year's activities and a discussion of whether changes are needed to the Quality Management Strategy. There will be five primary focus areas: These areas are described below.
-
1)Structure of the QMC: The group will review the structure of the QMC to determine if it is effective.
-
2)Trend Analysis: The group will evaluate the processes for identifying trends and patterns to assure that issues are being identified.
-
3)Systems Improvement Log: The group will review 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 will be evaluated to determine its effectiveness.
-
5)Performance Measures: The entities will determine whether to make changes in existing performance measures, add measures, or discontinue measures. Other elements of performance measures will also be reviewed for effectiveness, including: the frequency of data collection, source of data, sampling methodology, and remediation.

-
The State will continually strive 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.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

(a) Requirements concerning the independent audit of provider agencies;
The OA, DHS-DRS, completes a review of each In-home Service (homemaker) and Adult Day Care provider at a minimum of every two years to ensure compliance with program regulations. The compliance review is conducted on all agencies that have current rate agreements with DHS-DRS for the purpose of determining compliance and/or continued compliance with the Administrative Code: Title 89: Social Services, Chapter IV: Department of Human Services, Subchapter d: Home Services Program, Part 686 Provider Requirements, Type Services, and Rates of Payment. The OA also reserves the right to require the In-home Service Agency to engage an independent certified public accounting agency to verify the information and data submitted by the In-home Service Agency if the OA has reason to suspect the information and data sent is inaccurate, incomplete, or fraudulent.
The Auditor General jurisdiction is specified in 30 Illinois Compiled Statutes (ILCS) 5/3. Section 3-2 of the statute identifies the mandatory post audits. In conjunction with the MA 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.
In addition to the audits required by law, the OA reviews fiscal activity for cases that are reviewed for quality assurance. To ensure proper identification of participants and providers, all participants' social security numbers are verified for accuracy through the Social Security Administration database, and all providers' employer identification numbers are likewise verified prior to enrollment as a Medicaid provider.
(b) The financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits;
The MA has implemented oversight procedures that provide increased assurance that claims are coded and paid in accordance with the reimbursement methodology specified in the waiver. These processes enable staff to monitor the financial aspects of the persons with HIV/AIDS waiver from a global perspective, rather than review a sample of paid claims.
The Medicaid Agency produces exception reports that identify service claims paid to clients who were in a nursing home or who were deceased. In addition, the MA will identify claims paid for clients who were not eligible on the date of service and will identify paid claims that exceeded the allowable rate.
The MA staff utilizes its Data Warehouse query capability to analyze the entire dataset of paid waiver claims. The MA utilizes an exception report and review format as a component of the agency's financial accountability activity. The MA has constructed database queries that encompass waiver eligibility, coding and payment criteria. Based on these criteria, twice a year the MA conducts analysis of all paid claims and only the claims that were not paid in accordance with set parameters are identified and extracted. This review will include capitation payments made to MCOs and encounter claims submitted by MCOs.
The identified exceptions are printed out with all relevant service data. Current exception reports identify paid claims for waiver services to clients who were in a nursing home or who are deceased. In addition to the exception reviews of waiver claims, MA conducts targeted reviews of individual waiver services, utilization of waiver services by participant and billing trends and patterns of providers. The MA conducts a 100% review of the PMs in appendix I.
When a case of fraud or inappropriate billing is suspected, a more detailed review of services and claims will be conducted. Claims and eligibility information are extracted from the data warehouse and reviewed in more detail. Death dates are verified to SSA/SSI death dates. Nursing home stays are compared to overlapping waiver services. If inappropriate billing is discovered, the claim is adjusted or voided by the OA to reduce the state's claim for FFP. The OA will contact the provider to collect any overpayment. In cases of fraud, the HSP Medicaid Fraud Unit contacts the OA who will set up a receivable for any court-ordered restitution. The OA will also void or adjust any claims related to the restitution.
The results of all financial reviews are presented in writing to the OA with supporting claim detail. The OA advises the MA of corrective actions taken, including adjustments, for all service claims identified by the reviews that were not paid in accordance with defined parameters.
The MA and OA work cooperatively to review rates and provider claims. The MA implements procedures that provide assurance that claims will be coded and paid in accordance with the reimbursement methodology specified in the waiver. For participants enrolled in an MCO, the MA'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 ICP, and subsequent managed care expansion. 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. Post-payment review results are communicated to the providers by the OA.
The OIG will acquire the necessary data from the OA subsystems some of which is fed through the MMIS system for billing purposes. This "raw" data would provide the OIG with a broad source upon which to apply routines developed for the MA's in-house analytic system. Based upon other "waiver" programs, the OIG has developed many routines and profiles used in analysis detection and investigation of potential fraud, waste and abuse. This analysis for PA detail services and

payment information will allow the OIG to have a better position to perform data fraud routine investigations. This will detect irregularities in PA services during any hospital/nursing home stay, service outlier cross-match validation among medical services along with external network analysis, and the potential recipient medical necessity study for the PA services.
Beginning January 1, 2014, the OA will implement the Electronic Visit Verification process. This will require all individual providers as well as agency providers going to call a toll-free line when entering and leaving the customer's home. This will verify start and end times, and will also facilitate tracking of customer service provision.
The OA utilizes an Electronic Visit Verification system to verify that participants receive authorized services in accordance with approved service plans as well as program policy. Providers call EVV the moment they begin providing services and call again when they finish. Every two weeks the provider completes and submits a timesheet to the OA field office that is approved by the customer and authorizes payment for services rendered. Real-time EVV data is available for viewing by OA staff when paying timesheets and is used to verify the actual start and end times worked by the provider.
Not only does this process help to reduce fraudulent activity by the provider and identify potential policy violations, but also serves to help determine if the customer has the capacity to supervise the provider. The participant signs the timesheet, verifying the authenticity of the hours worked, and approving payment. If submitted timesheet in/out times do not match EVV call data, this can result in a non-compliance event. Three such events within a six-month period may indicate participant inability to appropriately manage the provider. This may result in the OA counselor decision to move services to an agency provider if the counselor believes the participant unable to appropriately manage the individual provider. The participant has the right to appeal this decision.
Customers are educated about prevention of, and reporting fraud as well as abuse during all assessments. The customer signs the Application and Redetermination of Eligibility Agreement, and verifies that they have been informed about these issues. The provider signs a Waiver Program Provider Agreement form that verifies that they will accurately report time worked. The following documents also stipulate that the customer and/or provider will not participate in fraudulent activities: Individual Provider Standards (signed by customer and provider); Individual Provider Payment Policies (signed by customer and provider); and Home Services Timesheet (signed by customer and provider).

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
50I: # and % of payments that were paid for service that were specified in the

participant's service plan. N: # of payments made to the OA and MCO that are specified in the participant's service plan. D: total # of OA and MCO payments.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS Medical Data Warehouse and WebCM

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:* *Non-representative sample*
	☒ ***Other*** *Specify:* *Semi-Annually*	

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 Reports*	☒ ***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***

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

Performance Measure:
48I: # and % of payments that were paid using the correct rate as specified in the waiver application. N: # of OA payments to the OA and MCO 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:*	

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
49I: # and % of payments that were paid for participants who were enrolled in the waiver on the date the service was delivered. N: # of payments to the OA and MCO that were paid for participants who were enrolled in the waiver on the date the service was delivered. D: Total # of OA and MCO payments.

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

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

	☒ ***Other*** *Specify:* *Semi-Annually*	

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 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.

Performance Measure:
 # and % of rates consistent with the approved rate methodology over the five year waiver cycle. N: Number of rates consistent with approved rate methodology for the five year waiver cycle. D: Number of approved rates.

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

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

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

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

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

The Medicaid agency, MA, will conduct routine programmatic and fiscal monitoring for 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 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 Medicaid agency reviews the entire DHS claim to Medicaid administrative costs.

For the waiver claims review, the Medicaid Agency (HFS) 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.

In the MA's contracts with Integrated Care Program 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.

As part of the MA's quality oversight and monitoring of the waiver providers, the EQRO will perform quarterly onsite audits of the enrollee care plans through chart validation. This information will be submitted to the MA for review and analysis.

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.

b. Methods for Remediation/Fixing Individual Problems

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

48I:The MA will require that the OA to either recoup the overpayment or repay at correct rate. If necessary, will also adjust the federal claim. Remediation must be completed within 30 days. The MA will require the MCO to recoup the overpayment or repay at correct rate. Remediation must be completed within 30 days.

49I:The MA 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. The MA will adjust the federal claim for services provided by the MCO prior to the customers' waiver enrollment. Remediation must be completed within 30 days.

50I:The OA/MCO will determine whether the service was authorized. If authorized, the OA/MCO will revise customer service plan; If not authorized, the OA/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:*	☐ ***Annually***
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *Bi-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).*

The Department of Healthcare and Family Services (HFS), Illinois' State Medicaid Agency, retains and exercises final authority over payment rates. It does so in collaboration with the waiver's operating agency, the Illinois Department of Human Services, Home Services Program, which develops the proposed rates and shares the proposed rates and methodology with HFS for its approval. Rates of payment for program services since the initial 1915(c) waiver was approved have been established and updated as described below.
The rates are available to the public through the OA's website: http://www.dhs.state.il.us/page.aspx?item=83520
Personal Assistant: Until July 2003, Personal Assistants were paid Illinois minimum wage as required by state statute and as formally established by the General Assembly in the Home Services Program (HSP) enabling legislation (20 ILCS 2405/3(f)) [originally(g)]. In March 2003, following a decision by the State Labor Relations Board, the Governor of Illinois signed Executive Order 2003-8 requiring an election to determine labor representation of personal assistants. SEIU won the election and was recognized as the sole and exclusive bargaining unit for personal assistants in the HSP. Negotiations commenced and a four year agreement was signed which specified the rates of payment for that time period. The Labor Relations Act was formally changed 7/26/03, to specify SEIU's status in this regard. In July 2007, a second four year agreement was negotiated which likewise specified rates of payment for the contract period. A third agreement for a three year contract period became effective in July 2011. Although that agreement should have expired in July 2014, the rate in June 2014 has remained in effect while negotiations continued. On March 14, 2019, a one-time settlement agreement was reached to raise individual provider wages by $0.48 per hour. Contract negotiations continue. Below are the rates for individual providers that are affected by this change:
Personal Assistant: $13.48
The SEIU agreement indicates that hourly direct care staff rates receive periodic flat rate adjustments. In accordance with recent FLSA regulations, the State also allows for overtime and travel reimbursement to personal assistants. The rates do not include any direct or indirect administrative costs, are not geographically based, and exclude room and board costs. Rates are available to the public through the SEIU website and the Illinois Central Management Services website. The labor agreement is also posted on the OA's website under the HSP.
Home Health Extended State Plan and "Other" Services: Home Health Extended State Plan and "Other" Services include: registered nurses, licensed practical nurses, intermittent nurse visits, HH Aides (CNAs) and therapists (OT, Speech and PT). The OA pays different rates depending on whether the service is provided by a licensed home health agency or by an independently licensed or certified provider.
Historically, the independently licensed or certified provider rates were negotiated on an individual participant basis with rate ceilings based on the prevailing wage rates for these providers statewide. Beginning in July 2012, the SEIU contract was expanded to include independently licensed or certified providers using a fixed rate schedule for each type of service. The rates are available to the public through the SEIU website and the Illinois Central Management Services website in the published labor agreement. The labor agreement is also posted on the OA's website under the HSP. All home health rates are the same statewide except for children's agency rates which differ geographically. In accordance with recent FLSA regulations, the State also allows for overtime and travel reimbursement to home health service providers. Current rates for individual home health providers are: RN: $29.75, LPN: 23.00, and CNA (home health aide): $ 16.00, physical therapist: $37.00, occupational therapist: $37.00, speech therapist (non-hospital): $37, speech therapist (hospital): $50.00. Current rates for nursing services provided through agencies: RN: $ 29.55, LPN: 25.47, and CNA (home health aide): $ 13.75.
Pursuant to the one-time settlement agreement that was reached with SEIU on On March 14, 2019, to raise individual provider wages, the following increases are proposed for individual nursing providers:
Registered Nurse: $30.23
Licensed Practical Nurse: $23.48
Certified Nurse Assistant: $16.48
Homemaker rates are fixed unit rates based on the rates established by the Illinois Department on Aging (IDoA) in the Elderly Waiver (0143). To establish the initial rate in the original, 1982 joint Aging and Disability waiver, IDoA employed a Request for Proposals (RFP) process through which 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. Homemaker service providers are required to expend a minimum of 77% of their total CCP revenues on direct service worker costs. The remaining 23% of revenues may be spent by the provider agencies at their discretion on administrative or program support costs. See 89 IAC 240.2040. Expenses that may be counted as direct service worker costs include wages, health coverage, retirement, FICA, uniforms, workers compensation, travel reimbursement, FUTA and unemployment insurance (UI). Program support and administrative expenses include direct service worker supervisor costs, training costs, malpractice insurance, administration staff costs, consultant fees, supplies and equipment, telephone service, occupancy costs and postage. 89 IAC 240.2050.
Subsequent rates added cost of living adjustments (COLAs) to the previous rates or reflected changes negotiated as part

of collective bargaining agreements between the State and SEIU. The in-home service rates were increased on January 1, 2003, and June 1, 2006, as a result of action taken by the Administration and General Assembly. Effective 7/1/08, an agreement between the State and SEIU raised the in-home services (homemaker) rate to coincide with the three-step increase in the federal Fair Minimum Wage Act of 2007. Also, effective July 1, 2008, the rate was enhanced pursuant to Illinois Public Act 95-713, to cover health insurance costs. Effective 8/1/17, Illinois Public Act 100-0023 provided for an increase to both the in-home service rate and the enhanced rate paid to service provider agencies that offer health insurance coverage. This Public Act further provided that the enhanced rate shall be adjusted using actuarial analysis based on the cost of care. Based upon this legislation the current homemaker rate is a fixed unit rate of $18.29 per hour of service. Based upon a recent rate study completed by IDOA, the proposed rate is indicated below:
Homemaker: $20.28
The in-home service (homemaker) rates include administrative costs and direct care staff wages. The rates are not geographically based and do not include room and board.
In-home services (homemaker) rates are reviewed by IDoA annually to ensure budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. In reviewing fixed unit rates of reimbursement, the State takes into consideration (1) service utilization and cost information, and (2) current market conditions and trend analyses.
Adult Day Care Service rates are based on rates established by the IDoA in their elderly Waiver (0143). The fee-for-service reimbursement rate structure consists of two fixed unit rates, one for ADC and another for ADC transportation. The initial unit rate for ADC was established based on five direct client contact hours per day (excluding transportation), but the unit rate was changed in April 1996, when the definition of an ADC unit was changed to allow one hour to equate to one unit of service to reflect the business practices and operating hours of the participating provider industry as well as client and family preference.
ADC rates include both administrative and direct care costs. They are not geographically based and do not include room and board. Since the original ADC rates were established, they have been updated to include legislatively negotiated cost of living adjustments. Two such updates occurred effective 1/1/03 (for all ADC rates), and 7/1/06 (for the transportation component). In addition, ADC rates are reviewed annually by IDoA to ensure budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. In addition to providing ADC services, ADC transportation services are also covered through the waiver. This insures timely and accessible customer access to ADC services. The current ADC rate is $9.02 per hour of service and ADC Transportation is $8.30 per trip. Based upon a recent rate study completed by IDOA, proposed ADC/ADC Transportation rates are indicated below:
ADC: $14.30
ADC Transportation: $10.29
Continue to Main B Optional.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Provider Payment
The operating agency (DHS) pays the provider directly. The three-party Medicaid waiver provider agreement is on file with the Medicaid agency and it allows the provider to voluntarily reassign payment to the operating agency. If a provider chooses to receive payment directly from the Medicaid agency, the provider will sign the standard Medicaid provider agreement (HFS 1413). Providers may receive payment directly from the Medicaid agency, if they choose not to voluntarily reassign payment to the Operating agency.
DHS maintains a computerized payment system that includes service plan authorization for each individual, payments to provider agencies, units of service delivered to each eligible individual, and payment and claiming rates per unit of service.
DHS authorizes services, in advance of service delivery. Both the provider and the customer report and certify that the service was delivered and the HSP counselor approves payment for the service. A combination authorization/voucher document is utilized in this payment process and constitutes a legal agreement between DHS and the provider. Services are authorized and vouchered for no more than one calendar month.
The DHS payment system contains edits to ensure that payments are made only when the individual is authorized for the program services delivered, via a service plan that specifies the program services, the provider of the program services, and the amount of services authorized.
Operating agency claims processing
Payments are made by the State of Illinois Comptroller's Office from DHS' appropriation. DHS then submits the amount of expenditures for Medicaid eligible recipients to HFS for submission of federal financial participation.
Medicaid agency claims processing
The operating agency waiver claiming data is 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.
Provider rates may be viewed at this link: http://www.dhs.state.il.us/page.aspx?item=83520

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:*

Operating Agency

The OA validates that provider billings match the effective date of the participant's authorization for services as included in an approved plan of care. Participants sign time sheets to verify that services were performed in accordance with the plan of care.

Paid claims are passed through to the MA and MMIS processing edits are applied for Medicaid and waiver eligibility. The MA performs post-payment plan of care and financial reviews.

Electronic Visit Verification (EVV) system

Pursuant to the Public Act 097-0689, the OA is required to implement electronic service verification based on global positioning system or other cost-effective technology for the Home Services Program. The purpose of this legislation is to enhance error rate reductions in billings, safeguard against fraud, and improve program management both on the service delivery end for HSP customers and at the OA's operating oversight level.

The OA implementation target date is January 1, 2014. Systems will be developed to accept time from an Electronic Visit Verification (EVV) system and to accommodate the process since independent personal assistants account for 85% of service time. Once established, all HSP independent and In-home Service (agency homemaker) providers will be required to utilize one or more EVV systems (e.g., telephony, mobile/GPS, and/or fixed visit verification devices) from an OA certified EVV vendor of their choice. All employed EVV systems will be required to electronically and accurately document and track login and logout time of visits by the independent or in-home service provider in the participant's residence in accordance with the participant's authorized plan of care. The EVV solutions must also comply with promulgated standards and offer Interoperability with the OA's billing and other data exchanges for compliance and auditing purposes.

Managed Care

The MA pays a monthly capitated rate 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 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 Department any discrepancies. The MCOs must comply with sections 4.1 and 4.2 of the MMAI contract on Payment and financial provisions.

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 waiver application will be updated to include additional detail

The Plans are required to have internal processes to validate payments to waiver providers. The Plan's 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.

Providers entering the customer's home will use the customer's phone to call in to a central number. They will have

previously set up voice verification that will be associated with their unique identification code. The code will be entered at the time. The same process will occur when exiting the home. This 'locks in' the actual times the provider enters and leaves the home. The customer verifies that the services were provided by electronically approving the submitted times. If the customer cannot access the internet, a paper version of the time will be submitted to local HSP offices that will verify the time worked. Timesheets will be compared to entry/exit times on a data report, and if appropriate will be approved by OA staff.
If inappropriate billing is discovered, the claim is adjusted or voided by the OA to reduce the state's claim for FFP. The OA will contact the provider to collect any overpayment. In cases of fraud, the HSP Medicaid Fraud Unit contacts the OA who will set up a receivable for any court-ordered restitution. The OA will also void or adjust any claims related to the restitution. When inappropriate billings are paid, the OA contacts the provider to collect the overpayment. The claim is voided and transmitted to the MA. The voided claim reduces the state's claim for FFP through an adjustment process.

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:

DHS-Division of Rehabilitation Services, the OA makes provider payments from a central computer system. Claims are edited and then sent to the MA 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.

The MA makes monthly capitated rates payments 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.***

☒ ***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 DHS-Division of Rehabilitation Services, the operating agency (OA).

Illinois has a state-operated payroll system for independent providers or providers that are participant-directed. The participants must sign service calendars to verify the hours worked. The independent (non-agency) provider sends the hours worked to the OA Aids Administration Unit, or in some cases the DRS HSP District Office, for review and approval. The payment is entered into the Web Case Management System that applies internal edits to assure that the correct rates and the claims are within the service cost maximum. The OA state operated payroll system pays independent providers twice monthly. The payroll system withholds unemployment, FICA, union dues and other deductions as requested by the providers.

Oversight by the Medicaid Agency

The OA makes payments directly to providers of waiver services and certifies those expenditures to the MA. The provider signs the three-party Medicaid provider agreement that allows voluntary reassignment of pay. The OA explains to the provider that the waiver agreement voluntarily reassigns payment responsibility to the OA, but that the provider has the option to bill the MA directly, if they choose.

The OA passes the detail expenditure data once a month via an electronic tape to the MA. The data is fed into the MMIS and is subject to edits to ensure the information provided is accurate and that the services and providers are eligible for federal match under Title XIX. Any claims with inaccurate information are rejected by the system and the file of the rejected claims is passed back to the OA for their review. Claims that pass through the system without error filter down to the MARS reporting unit. The MA MARS unit is responsible for generating the reports to the MA Bureau of Federal Finance (BFF) who use the reports to claim Medicaid expenditure data quarterly on the CMS 64. MARS also has a series of edits and codes that are used to filter data to ensure accuracy and to determine to what program the expenditure should be reported. The BFF report the expenditures on the CMS 64 on a quarterly basis 30 days after the quarter ends.

In accordance with the Cash Management Improvement Act (CMIA), the MA 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.

☒ ***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.

The only service that will have an enhanced rate is Homemaker Services. This service would be only for in-home service provider agencies that provide health insurance. The source of the non-federal share of the enhanced payments would be the State of Illinois. Each service provider that received the enhanced rate would be able to retain 100% of the total computable expenditure claimed by the Medicaid Agency to CMS. With the public notice and the continuous posting of the rate increase on the HFS website, it is believed that the public is fully aware and that the intent is clear as to which providers are eligible for the enhanced payment.

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.

The capitation payments made to the MCO's are not returned to the State so there is no disparity between the amounts actually paid to the MCO and the amount claimed to CMS.

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.

- ( ) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- (●) ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

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***
- [x] ***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	18353.43	10618.54	28971.97	17399.92	28437.42	45837.34	16865.37
2	18661.60	10966.65	29628.25	17577.45	29191.16	46768.61	17140.36
3	18687.07	11257.32	29944.39	17756.80	29964.87	47721.67	17777.28
4	18744.57	11590.82	30335.39	17937.97	30759.08	48697.05	18361.66
5	18802.04	11934.09	30736.13	18121.00	31574.35	49695.35	18959.22

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	1480	1480

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 2	1528		1528
Year 3	1576		1576
Year 4	1624		1624
Year 5	1672		1672

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 has been projected based on actual experience from the current waiver period (October 1, 2013 through September 30, 2018) reflecting year-over-year increases during the new 5 year waiver period based on projected phase-in and phase-out assumptions.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Estimates are based on historical trends, increases in service costs based on contractual agreements and anticipated increases in utilization. Historically the number of units per user has remained fairly stable. The average unit cost is based upon a number of factors including, but not limited to, inflationary service cost increases and pre-scheduled rate increases for personal assistant care and homemakers. Changes in utilization are trended from the last five years of waiver service utilization data.

The average cost per unit was maintained across the length of the renewal period. Services that were identified to have zero utilization in the historical claims experience were set at a utilization level of 1 and unit costs consistent with historically filed unit cost in the current waiver.

Fee-for-service Population:
To determine the fee for service projections the MA used trending from the prior five years to determine expected utilization for the duration of the renewal. The overall projections were then reduced to account for only the fee-for service population within the waiver. Overall trending for the services was kept in proportion to the original projections.

MCO Population:
The MA has distributed an average monthly capitation rate of $1,700 across the rate categories. The assumptions regarding the average length of stay on the waiver are the same for both the fee-for-service and MCO populations. The MA has also assumed that the average units per user would be consistent with the current Factor D. Additionally, the same ratio of users per service based on the current Factor D was used. The cost per unit of service was used as the residual calculation after determining the other variables.

Continued enrollment for the renewal period was developed based on actual enrollment data through the current waiver year four (10/1/16 – 9/30/17) along with consideration of additional slots consistent with historically filed unduplicated participant counts.

The Homemaker rate was raised from $17.14 to $18.29 to reflect the action of the Illinois General Assembly, Public Act 100-0023.

Factor D for waiver years 1 through 5 was projected in the following manner:

- *Average cost per unit projections were changed to reflect the State's fee schedule effective September 1, 2019 for the following services:*
  ADS from $9.02 per hour to $14.30 per hour;
  ADST from $8.30 per hour to $10.29 per hour;
  EHRS from $30 per installation to $40 per installation, and,
  In-home services from $18.29 per hour to $20.28 per hour.

The average cost per unit for waiver year 1 represents a blend of the historical fee schedule amounts for 11 months and the newly effective rates for 1 month. With the exception of in-home services, waiver years 2 through 5 average cost per unit projections reflect a complete year at the newly effective rates.

- *Average cost per unit projections were changed to reflect an additional fee schedule change effective January 1, 2020 for in-home services to $21.84 per hour. The average cost per unit for waiver year 2 represents a blend of the September 1, 2019 fee schedule amount for 3 months and the January 1, 2020 fee schedule amount for 9 months. The average cost per unit projections for waiver years 3 through 5 reflect a complete year at the January 1, 2020 fee schedule amount.*

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:*

Base year data reflects Waiver Year 3 of the current renewal (10/1/15 – 9/30/16) as reported in the Waiver Year 3 372 report Factor D' was trended at a rate of 2.7% per year based on historical experience and budget forecast trends for state plan services along with incremental growth for the change in average length of stay from the waiver year ending 9/30/16.
The capitation rate for waiver participants enrolled in Managed Care Organization includes both waiver services, as identified in Factor D, and ancillary medical and pharmacy services. The capitation rate is certified as actuarially sound. The capitation rate was developed based on historical fee-for-service costs for ancillary services for waiver recipients from state fiscal years 2008 through 2011. The historical ancillary service expenditures were trended forward to the contract rating years. Further, adjustments were applied for policy and program changes, as well as anticipated managed care impact adjustments. The capitation rate also includes an administrative and risk load appropriate for the MCO.
Since not all waiver recipients are enrolled in an MCO, Factor Dâ was developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.
The value of D' and G' is a 5 year trend of actual expenditures; Factor D' is trending less than Factor G'.

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:*

Base year data reflects Waiver Year 3 of the current renewal (10/1/15 – 9/30/16) as reported in the Waiver Year 3 372 report. Factor G was trended at a rate of 1% per year based on historical experience and budget forecast trends for nursing facility services.
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 is certified as actuarially sound. 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. Further, adjustments were applied for policy and program changes, as well as anticipated managed care impact adjustments. The capitation rate includes an administrative and risk load appropriate for the MCO.

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.

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:*

Base year data reflects Waiver Year 3 of the current renewal (10/1/15 – 9/30/16) as reported in the Waiver Year 3 372 report. Factor G' was trended at a rate of 2.7% per year based on historical experience and budget forecast trends for state plan services.

The capitation rate for 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 was developed based on historical fee-for-service costs for ancillary services for nursing facility residents from state fiscal years 2008 through 2011. The historical ancillary service expenditures were trended forward to the contract rating years. Further, adjustments were applied for policy and program changes, as well as anticipated managed care impact adjustments. The capitation rate includes an administrative and risk load appropriate for the MCO.

Since not all nursing home residents are enrolled in an MCO, Factor Gâ 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 Care	
Homemaker	
Personal Assistant	
Respite	
Home Health Aide	
Intermittent Nursing	
Occupational Therapy	
Physical Therapy	
Speech Therapy	
Environmental Accessibility Adaptations	
Home Delivered Meals	
In-Home Shift Nursing	
Personal Emergency Response System	
Specialized Medical Equipment	

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 Care Total:							19406.22
Adult Day Care	☐	Hour	2	837.72	9.46	15849.66	
Adult Day Care Transportation	☐	Trip	2	209.95	8.47	3556.55	
Homemaker Total:							1717682.51
Homemaker	☐	Hour	211	440.99	18.46	1717682.51	
Personal Assistant Total:							25177079.20
Personal Assistant	☐	Hour	1480	1308.58	13.00	25177079.20	
Respite Total:							3853.68

GRAND TOTAL:	27163073.73
Total: Services included in capitation:	
Total: Services not included in capitation:	27163073.73
Total Estimated Unduplicated Participants:	1480
Factor D (Divide total by number of participants):	18353.43
Services included in capitation:	
Services not included in capitation:	18353.43
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Health Aide (CNA)	☐	Hour	1	1.00	16.00	16.00	
Home Health Nursing care (RN)	☐	Hour	1	1.00	29.75	29.75	
Home Health Nursing Care (LPN)	☐	Hour	1	1.00	23.00	23.00	
Homemaker	☐	Hour	2	103.47	18.29	3784.93	
Home Health Aide Total:							123310.24
Home Health Agency (CNA)	☐	Hour	2	873.53	13.75	24022.08	
Home Health Non-Agency (CNA)	☐	Hour	17	365.03	16.00	99288.16	
Intermittent Nursing Total:							65.25
Home Health Visit	☐	Visit	1	1.00	65.25	65.25	
Occupational Therapy Total:							106.00
Occupational Therapy Over Age 18	☐	Hour	1	1.00	53.00	53.00	
Occupational Therapy Under Age 18	☐	Hour	1	1.00	53.00	53.00	
Physical Therapy Total:							106.00
Physical Therapy Over Age 18	☐	Hour	1	1.00	53.00	53.00	
Physical Therapy Under Age 18	☐	Hour	1	1.00	53.00	53.00	
Speech Therapy Total:							106.00
Speech Therapy Over Age 18	☐	Hour	1	1.00	53.00	53.00	
Speech Therapy Under Age 18	☐	Hour	1	1.00	53.00	53.00	
Environmental Accessibility Adaptations Total:							6726.34
Environmental Accessibility Adaptations	☐	Unit	2	1.00	3363.17	6726.34	

GRAND TOTAL:	27163073.73
Total: Services included in capitation:	
Total: Services not included in capitation:	27163073.73
Total Estimated Unduplicated Participants:	1480
Factor D (Divide total by number of participants):	18353.43
Services included in capitation:	
Services not included in capitation:	18353.43
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals Total:							**66757.50**
Home Delivered Meals	☐	Day	43	103.50	15.00	**66757.50**	
In-Home Shift Nursing Total:							**8777.89**
Home Health Agency Nursing (RN)	☐	Hour	1	1.00	29.55	**29.55**	
Home Health Non-Agency Nursing (RN)	☐	Hour	3	15.01	29.75	**1339.64**	
Home Health Agency (LPN)	☐	Hour	1	34.15	25.47	**869.80**	
Home Health Non-Agency (LPN)	☐	Hour	5	56.86	23.00	**6538.90**	
Personal Emergency Response System Total:							**38540.10**
Personal Emergency Response System	☐	Month	143	9.61	28.00	**38478.44**	
Personal Emergency Response System: Install	☐	Service	2	1.00	30.83	**61.66**	
Specialized Medical Equipment Total:							**556.80**
Special Medical Equipment	☐	Unit	1	1.00	556.80	**556.80**	

GRAND TOTAL:	**27163073.73**
Total: Services included in capitation:	
Total: Services not included in capitation:	27163073.73
Total Estimated Unduplicated Participants:	**1480**
Factor D (Divide total by number of participants):	**18353.43**
Services included in capitation:	
Services not included in capitation:	18353.43
Average Length of Stay on the Waiver:	327

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**28452.34**
Adult Day Care	☐	Hour	2	842.84	14.30	**24105.22**	
Adult Day Care Transportation	☐	Trip	2	211.23	10.29	**4347.11**	
Homemaker Total:							**2074738.81**
Homemaker	☐	Hour	218	443.69	21.45	**2074738.81**	
Personal Assistant Total:							**26152545.12**
Personal Assistant	☐	Hour	1528	1316.58	13.00	**26152545.12**	
Respite Total:							**3876.73**
Home Health Aide (CNA)	☐	Hour	1	1.00	16.00	**16.00**	
Home Health Nursing care (RN)	☐	Hour	1	1.00	29.75	**29.75**	
Home Health Nursing Care (LPN)	☐	Hour	1	1.00	23.00	**23.00**	
Homemaker	☐	Hour	2	104.10	18.29	**3807.98**	
Home Health Aide Total:							**129939.81**
Home Health Agency (CNA)	☐	Hour	2	878.87	13.75	**24168.92**	
Home Health Non-Agency (CNA)	☐	Hour	18	367.26	16.00	**105770.88**	
Intermittent Nursing Total:							**65.25**
Home Health Visit	☐	Visit	1	1.00	65.25	**65.25**	
Occupational Therapy Total:							**106.00**
Occupational Therapy Over Age 18	☐	Hour	1	1.00	53.00	**53.00**	
Occupational Therapy Under Age 18	☐	Hour	1	1.00	53.00	**53.00**	
Physical Therapy Total:							**106.00**
Physical Therapy Over Age 18	☐	Hour	1	1.00	53.00	**53.00**	

GRAND TOTAL:	**28514928.99**
Total: Services included in capitation:	
Total: Services not included in capitation:	28514928.99
Total Estimated Unduplicated Participants:	**1528**
Factor D (Divide total by number of participants):	**18661.60**
Services included in capitation:	
Services not included in capitation:	18661.60
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy Under Age 18	☐	Hour	1	1.00	53.00	53.00	
Speech Therapy Total:							106.00
Speech Therapy Over Age 18	☐	Hour	1	1.00	53.00	53.00	
Speech Therapy Under Age 18	☐	Hour	1	1.00	53.00	53.00	
Environmental Accessibility Adaptations Total:							6726.34
Environmental Accessibility Adaptations	☐	Unit	2	1.00	3363.17	6726.34	
Home Delivered Meals Total:							68725.80
Home Delivered Meals	☐	Day	44	104.13	15.00	68725.80	
In-Home Shift Nursing Total:							8831.52
Home Health Agency Nursing (RN)	☐	Hour	1	1.00	29.55	29.55	
Home Health Non-Agency Nursing (RN)	☐	Hour	3	15.10	29.75	1347.68	
Home Health Agency (LPN)	☐	Hour	1	34.36	25.47	875.15	
Home Health Non-Agency (LPN)	☐	Hour	5	57.21	23.00	6579.15	
Personal Emergency Response System Total:							40152.48
Personal Emergency Response System	☐	Month	148	9.67	28.00	40072.48	
Personal Emergency Response System: Install	☐	Service	2	1.00	40.00	80.00	
Specialized Medical Equipment Total:							556.80
Special Medical Equipment	☐	Unit	1	1.00	556.80	556.80	

GRAND TOTAL:	28514928.99
Total: Services included in capitation:	
Total: Services not included in capitation:	28514928.99
Total Estimated Unduplicated Participants:	1528
Factor D (Divide total by number of participants):	18661.60
Services included in capitation:	
Services not included in capitation:	18661.60
Average Length of Stay on the Waiver:	329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							28452.34
Adult Day Care	☐	Hour	2	842.84	14.30	24105.22	
Adult Day Care Transportation	☐	Trip	2	211.23	10.29	4347.11	
Homemaker Total:							2180292.66
Homemaker	☐	Hour	225	443.69	21.84	2180292.66	
Personal Assistant Total:							26974091.04
Personal Assistant	☐	Hour	1576	1316.58	13.00	26974091.04	
Respite Total:							3876.73
Home Health Aide (CNA)	☐	Hour	1	1.00	16.00	16.00	
Home Health Nursing care (RN)	☐	Hour	1	1.00	29.75	29.75	
Home Health Nursing Care (LPN)	☐	Hour	1	1.00	23.00	23.00	
Homemaker	☐	Hour	2	104.10	18.29	3807.98	
Home Health Aide Total:							135815.96
Home Health Agency (CNA)	☐	Hour	2	878.87	13.75	24168.92	
Home Health Non-Agency (CNA)	☐	Hour	19	367.26	16.00	111647.04	
Intermittent Nursing Total:							65.25

GRAND TOTAL:	29450820.67
Total: Services included in capitation:	
Total: Services not included in capitation:	29450820.67
Total Estimated Unduplicated Participants:	1576
Factor D (Divide total by number of participants):	18687.07
Services included in capitation:	
Services not included in capitation:	18687.07
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Health Visit	☐	Visit	1	1.00	65.25	65.25	
Occupational Therapy Total:							106.00
Occupational Therapy Over Age 18	☐	Hour	1	1.00	53.00	53.00	
Occupational Therapy Under Age 18	☐	Hour	1	1.00	53.00	53.00	
Physical Therapy Total:							106.00
Physical Therapy Over Age 18	☐	Hour	1	1.00	53.00	53.00	
Physical Therapy Under Age 18	☐	Hour	1	1.00	53.00	53.00	
Speech Therapy Total:							106.00
Speech Therapy Over Age 18	☐	Hour	1	1.00	53.00	53.00	
Speech Therapy Under Age 18	☐	Hour	1	1.00	53.00	53.00	
Environmental Accessibility Adaptations Total:							6726.34
Environmental Accessibility Adaptations	☐	Unit	2	1.00	3363.17	6726.34	
Home Delivered Meals Total:							70287.75
Home Delivered Meals	☐	Day	45	104.13	15.00	70287.75	
In-Home Shift Nursing Total:							8831.52
Home Health Agency Nursing (RN)	☐	Hour	1	1.00	29.55	29.55	
Home Health Non-Agency Nursing (RN)	☐	Hour	3	15.10	29.75	1347.68	
Home Health Agency (LPN)	☐	Hour	1	34.36	25.47	875.15	
Home Health Non-Agency (LPN)	☐	Hour	5	57.21	23.00	6579.15	
Personal Emergency Response System							41506.28

GRAND TOTAL:	29450820.67
Total: Services included in capitation:	
Total: Services not included in capitation:	29450820.67
Total Estimated Unduplicated Participants:	1576
Factor D (Divide total by number of participants):	18687.07
Services included in capitation:	
Services not included in capitation:	18687.07
Average Length of Stay on the Waiver:	329

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Personal Emergency Response System	☐	Month	153	9.67	28.00	41426.28	
Personal Emergency Response System: Install	☐	Service	2	1.00	40.00	80.00	
Specialized Medical Equipment Total:							556.80
Special Medical Equipment	☐	Unit	1	1.00	556.80	556.80	

GRAND TOTAL:	29450820.67
Total: Services included in capitation:	
Total: Services not included in capitation:	29450820.67
Total Estimated Unduplicated Participants:	1576
Factor D (Divide total by number of participants):	18687.07
Services included in capitation:	
Services not included in capitation:	18687.07
Average Length of Stay on the Waiver:	329

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							28538.72
Adult Day Care	☐	Hour	2	845.40	14.30	24178.44	
Adult Day Care Transportation	☐	Trip	2	211.87	10.29	4360.28	
Homemaker Total:							2254964.28
Homemaker	☐	Hour	232	445.04	21.84	2254964.28	

GRAND TOTAL:	30441188.12
Total: Services included in capitation:	
Total: Services not included in capitation:	30441188.12
Total Estimated Unduplicated Participants:	1624
Factor D (Divide total by number of participants):	18744.57
Services included in capitation:	
Services not included in capitation:	18744.57
Average Length of Stay on the Waiver:	330

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistant Total:							27880084.96
Personal Assistant	☐	Hour	1624	1320.58	13.00	27880084.96	
Respite Total:							3888.43
Home Health Aide (CNA)	☐	Hour	1	1.00	16.00	16.00	
Home Health Nursing care (RN)	☐	Hour	1	1.00	29.75	29.75	
Home Health Nursing Care (LPN)	☐	Hour	1	1.00	23.00	23.00	
Homemaker	☐	Hour	2	104.42	18.29	3819.68	
Home Health Aide Total:							142123.95
Home Health Agency (CNA)	☐	Hour	2	881.54	13.75	24242.35	
Home Health Non-Agency (CNA)	☐	Hour	20	368.38	16.00	117881.60	
Intermittent Nursing Total:							65.25
Home Health Visit	☐	Visit	1	1.00	65.25	65.25	
Occupational Therapy Total:							106.00
Occupational Therapy Over Age 18	☐	Hour	1	1.00	53.00	53.00	
Occupational Therapy Under Age 18	☐	Hour	1	1.00	53.00	53.00	
Physical Therapy Total:							106.00
Physical Therapy Over Age 18	☐	Hour	1	1.00	53.00	53.00	
Physical Therapy Under Age 18	☐	Hour	1	1.00	53.00	53.00	
Speech Therapy Total:							106.00
Speech Therapy Over Age 18	☐	Hour	1	1.00	53.00	53.00	
Speech Therapy Under Age 18	☐	Hour	1	1.00	53.00	53.00	

GRAND TOTAL:	30441188.12
Total: Services included in capitation:	
Total: Services not included in capitation:	30441188.12
Total Estimated Unduplicated Participants:	1624
Factor D (Divide total by number of participants):	18744.57
Services included in capitation:	
Services not included in capitation:	18744.57
Average Length of Stay on the Waiver:	330

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Accessibility Adaptations Total:							**6726.34**
Environmental Accessibility Adaptations	☐	Unit	2	1.00	3363.17	**6726.34**	
Home Delivered Meals Total:							**72070.50**
Home Delivered Meals	☐	Day	46	104.45	15.00	**72070.50**	
In-Home Shift Nursing Total:							**8858.08**
Home Health Agency Nursing (RN)	☐	Hour	1	1.00	29.55	**29.55**	
Home Health Non-Agency Nursing (RN)	☐	Hour	3	15.15	29.75	**1352.14**	
Home Health Agency (LPN)	☐	Hour	1	34.46	25.47	**877.70**	
Home Health Non-Agency (LPN)	☐	Hour	5	57.38	23.00	**6598.70**	
Personal Emergency Response System Total:							**42992.80**
Personal Emergency Response System	☐	Month	158	9.70	28.00	**42912.80**	
Personal Emergency Response System: Install	☐	Service	2	1.00	40.00	**80.00**	
Specialized Medical Equipment Total:							**556.80**
Special Medical Equipment	☐	Unit	1	1.00	556.80	**556.80**	

GRAND TOTAL:	**30441188.12**
Total: Services included in capitation:	
Total: Services not included in capitation:	30441188.12
Total Estimated Unduplicated Participants:	**1624**
Factor D (Divide total by number of participants):	**18744.57**
Services included in capitation:	
Services not included in capitation:	18744.57
Average Length of Stay on the Waiver:	330

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields.*

All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**28625.11**
Adult Day Care	☐	Hour	2	847.96	14.30	**24251.66**	
Adult Day Care Transportation	☐	Trip	2	212.51	10.29	**4373.46**	
Homemaker Total:							**2330048.67**
Homemaker	☐	Hour	239	446.39	21.84	**2330048.67**	
Personal Assistant Total:							**28791070.88**
Personal Assistant	☐	Hour	1672	1324.58	13.00	**28791070.88**	
Respite Total:							**3900.14**
Home Health Aide (CNA)	☐	Hour	1	1.00	16.00	**16.00**	
Home Health Nursing care (RN)	☐	Hour	1	1.00	29.75	**29.75**	
Home Health Nursing Care (LPN)	☐	Hour	1	1.00	23.00	**23.00**	
Homemaker	☐	Hour	2	104.74	18.29	**3831.39**	
Home Health Aide Total:							**148467.77**
Home Health Agency (CNA)	☐	Hour	2	884.21	13.75	**24315.78**	
Home Health Non-Agency (CNA)	☐	Hour	21	369.50	16.00	**124152.00**	
Intermittent Nursing Total:							**65.25**
Home Health Visit	☐	Visit	1	1.00	65.25	**65.25**	
Occupational Therapy Total:							**106.00**
Occupational Therapy Over Age 18	☐	Hour	1	1.00	53.00	**53.00**	
Occupational Therapy Under Age 18	☐	Hour	1	1.00	53.00	**53.00**	

GRAND TOTAL:	**31437014.18**
Total: Services included in capitation:	
Total: Services not included in capitation:	*31437014.18*
Total Estimated Unduplicated Participants:	**1672**
Factor D (Divide total by number of participants):	**18802.04**
Services included in capitation:	
Services not included in capitation:	*18802.04*
Average Length of Stay on the Waiver:	331

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Physical Therapy Total:							106.00
Physical Therapy Over Age 18	☐	Hour	1	1.00	53.00	53.00	
Physical Therapy Under Age 18	☐	Hour	1	1.00	53.00	53.00	
Speech Therapy Total:							106.00
Speech Therapy Over Age 18	☐	Hour	1	1.00	53.00	53.00	
Speech Therapy Under Age 18	☐	Hour	1	1.00	53.00	53.00	
Environmental Accessibility Adaptations Total:							6726.34
Environmental Accessibility Adaptations	☐	Unit	2	1.00	3363.17	6726.34	
Home Delivered Meals Total:							73862.85
Home Delivered Meals	☐	Day	47	104.77	15.00	73862.85	
In-Home Shift Nursing Total:							8884.64
Home Health Agency Nursing (RN)	☐	Hour	1	1.00	29.55	29.55	
Home Health Non-Agency Nursing (RN)	☐	Hour	3	15.20	29.75	1356.60	
Home Health Agency (LPN)	☐	Hour	1	34.56	25.47	880.24	
Home Health Non-Agency (LPN)	☐	Hour	5	57.55	23.00	6618.25	
Personal Emergency Response System Total:							44487.72
Personal Emergency Response System	☐	Month	163	9.73	28.00	44407.72	
Personal Emergency Response System: Install	☐	Service	2	1.00	40.00	80.00	
Specialized Medical							556.80

GRAND TOTAL:	31437014.18
Total: Services included in capitation:	
Total: Services not included in capitation:	31437014.18
Total Estimated Unduplicated Participants:	1672
Factor D (Divide total by number of participants):	18802.04
Services included in capitation:	
Services not included in capitation:	18802.04
Average Length of Stay on the Waiver:	331

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Equipment Total:							
Special Medical Equipment	☐	Unit	1	1.00	556.80	556.80	

GRAND TOTAL:	**31437014.18**
Total: Services included in capitation:	
Total: Services not included in capitation:	31437014.18
Total Estimated Unduplicated Participants:	**1672**
Factor D (Divide total by number of participants):	**18802.04**
Services included in capitation:	
Services not included in capitation:	18802.04
Average Length of Stay on the Waiver:	331