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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

Request for 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 Children who are Medically Fragile, Technology Dependent

C. **Waiver Number:IL.0278**
Original Base Waiver Number: IL.0278.90.R1.01

D. **Amendment Number:**

E. **Proposed Effective Date:** *(mm/dd/yy)*
10/01/16
Approved Effective Date of Waiver being Amended: 09/01/12

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The purpose of this amendment is to expand the waiver eligibility group to include clients who had been waiver participants before turning 21 years of age and are now over 21 years of age.

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	Amendm
☐ Appendix A – Waiver Administration and Operation	
☑ Appendix B – Participant Access and Eligibility	B-1, B-3

☑ **Appendix C – Participant Services**	C-1/C-3
☐ **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**	J-1, J-2

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 Children who are Medically Fragile, Technology Dependent

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.0278
Draft ID: IL.002.04.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 09/01/12
Approved Effective Date of Waiver being Amended: 09/01/12

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*):

- [x] **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**

- [x] **Nursing Facility**

  Select applicable level of care

  - (●) **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

- (●) **Not applicable**
- ( ) **Applicable**

  Check the applicable authority or authorities:

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

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

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

    - [ ] **§1915(b)(1) (mandated enrollment to managed care)**
    - [ ] **§1915(b)(2) (central broker)**
    - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
    - [ ] **§1915(b)(4) (selective contracting/limit number of providers)**
  - [ ] **A program operated under §1932(a) of the Act.**

    Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

The Illinois home and community-based services waiver for individuals who are medically fragile, technology dependent (MFTD) allows eligible children and adult former waiver participants to receive medically necessary supports in their own homes. The goal is to provide those needed supports in a way that maximizes independence and community integration. The waiver is intended to supplement supports for eligible children who are medically fragile, technology dependent, by providing waiver specific services and other medically necessary services for those whose medical needs meet the institutional level of care. The waiver includes the following services: respite, specialized medical equipment and supplies, environmental modifications, family training, nurse training, placement maintenance counseling, and medically supervised day care. For the adult population, the waiver includes two additional services: In-home shift nursing and certified nursing assistant.

The waiver is administered through the Department of Healthcare and Family Services (HFS), the Medicaid agency (MA) with day to day operations provided by the University of Illinois at Chicago, Division of Specialized Care for Children (DSCC), the operating agency (OA). The MA and DSCC have entered into an interagency agreement that outlines the respective roles and responsibilities. The interagency agreement is reviewed annually and updated as needed.

Eligibility:

The OA, as the single point of entry, accepts referrals for the waiver applications. Waiver eligibility determinations are conducted by skilled medical professionals employed by the OA. Applicants and enrollees must meet a minimum score on the MA approved level of care (LOC) tool to be eligible for the waiver. The MA has final approval of all eligibility determinations.

Care Coordination and Support Planning:

Once eligibility is established, the OA's team of licensed professionals (registered nurses, social workers, respiratory therapists and speech therapists) will provide ongoing care coordination. The Individual Support Plan (ISP) will be developed jointly with the family and participant, the DSCC care coordination team, and others as designated by the family.

The individual support plan will be participant centered and will be based on a comprehensive assessment of support needs and available resources. The care coordinator will assist the family to access needed waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source. The family and participant will guide the support plan and utilization of services based on their preferences and goals. The intensity of care coordination will be based on assessment of risk.

Health and Safety:

Risk-Based Care Coordination: The OA has developed a risk-based care coordination model. The care coordinator will use assessment information to determine the intensity of care coordination for each waiver participant. The amount and intensity of care coordination will be based on several risk factors and will be established based on the individual participant's needs.

Incident Reporting: The OA is responsible for receiving and acting on incidents involving waiver participants, and tracking activities to resolution. The OA provides a summary of incidents, including abuse, neglect and exploitation, to the MA at least quarterly during quality meetings, unless more immediate reporting is indicated. The MA and OA maintain ongoing communication.

Quality Improvement:

The OA will conduct ongoing quality assurance of care coordination activities, and the nursing agency and home medical equipment providers, including provider qualifications and training. The MA conducts separate quality assurance reviews of the OA to ensure compliance with delegated activities in the approved waiver.

The MA meets quarterly with the OA to discuss quality assurance reports, evaluate performance measures, and review incidents. The MA and OA identify trends based on scope, severity, changes and patterns of compliance. Identified trends are discussed and analyzed regarding cause, contributing factors and opportunities for system improvement.

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:
1) Family Advisory Council

The Division of Specialized Care for Children established a Family Advisory Council in July 1999. This advisory council meets three times per year, usually in March, June and November, to provide guidance and direction to the DSCC. Council members are selected to represent the cultural, social and geographic diversity of the Illinois children with special health care needs receiving agency services. The Council is coordinated by a parent, who serves as the agency's Family Liaison Specialist. This position coordinates the Council meetings and serves as a liaison for staff and families.

The link on the DSCC web-site about the FAC is:
http://internet.dscc.uic.edu/dsccroot/parents/adv_council.asp

2) Stakeholder Meetings

The Medicaid Agency (MA) held seven stakeholder meetings between June 2011 and February 2012. Information on the stakeholder groups may be found at: http:///hfs.illinois.gov/ccmn/

Meeting discussions focused on what is and what is not working in the care delivery system for children with complex medical needs and what components a new system should include. Discussions included topics on the universe of children to be served; acuity levels that may drive the service levels and payment system; how to incentivize care

coordination entities; range of services that would be covered by care coordination entities; creation of an unique provider type to provide tasks normally provided by licensed nurses; and cost-sharing by parents to pay for services. The last meeting focused on performance outcomes unique to children with complex medical needs.

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: Classen

First Name: Kris

Title: Acting Waiver Manager, Bureau of Long Term Care

Agency: Department of Healthcare and Family Services

Address: 401 S. Clinton Street, 4th Floor

Address 2:

City: Chicago

State: **Illinois**

Zip: 60607

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

Fax: (312) 793-5278

E-mail: Kris.Classen@illinois.gov

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

Last Name: Milburn

First Name: Mary

Title: Associate Director of Operations

Agency: University of Illinois-Chicago, Division of Specialized Care for Children

Address: 3135 Old Jacksonville Road

Address 2:

City: Springfield

State: **Illinois**

Zip: 62707-6488

Phone: (217) 558-2350 **Ext:** ☐ **TTY**

Fax: (217) 558-0773

E-mail: mmilbu2@exchange.dscc.uic.edu

8. Authorizing Signature

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Illinois**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

Attachments

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

- [x] **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:

This amendment would allow clients who would otherwise age out to remain in the waiver with the same services and care coordination. For clients who would return to the wavier from another program, the transition would be coordinated by DSCC care coordinators. These adults clients would be served by the same provider agencies under the same quality assurance standards as apply for all other waiver participants.

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 following represent key components of the Statewide Transition Plan and represent language taken directly from the Plan.

The HCBS regulations require States to ensure that individuals receiving Long-Term Services and Supports (LTSS) have full access to the benefits of community living and the opportunity to receive services in the most-integrated setting appropriate and that those rights and privileges are comparable to those afforded to Non-Waiver participants in the community.

In the spring of 2014, the Illinois Department of Healthcare & Family Services (HFS) convened an LTSS Inter-Agency workgroup consisting of representatives of: HFS as the State Medicaid Authority responsible to federal CMS for oversight of the State's nine 1915(c) Waivers; the Illinois Department of Human Services (DHS) and its Divisions of Developmental Disabilities (DDD), Mental Health (DMH), Alcoholism and Substance Abuse (DASA), Rehabilitation Services (DRS); the University of Illinois at Chicago Division of Specialized Care for Children (DSCC); and the Illinois Department on Aging (IDoA).

Illinois' Statewide Transition Plan included an assessment of existing State statutes, regulations, standards, policies, licensing requirements, and other provider requirements, including whether waiver settings' comply with the regulations as outlined at 42 CFR 441.301(c)(4)(5) and 42 CFR 441.710(a)(1)(2). Furthermore, the Statewide Transition Plan describes the remediation steps Illinois plans to implement to assure full and on-going compliance with the HCBS settings requirements, with specific timeframes for already-identified actions and deliverables.

HFS contracted with the University of Illinois Springfield (UIS) Survey Research Office to assist the LTSS Inter-Agency workgroup with the development of the methodology for the residential and non-residential settings surveys, including the development of survey questions and analysis of survey responses, to provide the State with a non-biased assessment of current practices. The survey questions were reviewed by each State agency, tested with staff from several community-based HCBS waiver residential settings and revised by the workgroup so as to be inclusive of the variety of services offered in Illinois' residential and non-residential HCBS settings. Two versions of the survey were created: one for residential settings and one for non-residential settings providing HCBS waiver services. Completion of the surveys by individual setting/sites was required.

The State held a webinar on February 11, 2015. This webinar was targeted to – HCBS waivers providers and provider organizations and to HCBS waiver participants and their families, guardians and representatives. In addition, six Regional Public Listening Forums were held at accessible locations throughout the State during the 32-day public comment period originally planned for January 15, 2015 - February 15, 2015 and subsequently extended to February 24, 2015. There was no cost to attend. Parking was available at all locations and accommodations were provided when requested to anyone who might need assistance with communication. Attendees were informed of the new HCBS regulations and its implications for HCBS settings and were given the opportunity to provide feedback and to ask questions. Those who commented were asked to submit a written version of their comments at the Forum. All written received and oral comments were transcribed and included in the Transition Plan.

Based upon follow-up site validation visits to provider settings, the State agencies under whose jurisdiction these settings operate along with HFS, will notify providers who are not in compliance with the new regulations. Specific explanations are to be presented to the providers regarding areas of their service setting and practice which do not comply with the new regulations.

The State intends to make a recommendation as to whether Illinois' HCBS settings qualify for "Heightened Scrutiny" on a case-by-case basis.

The State intends to work with HCBS waiver providers to bring their settings into compliance with the new regulations. When remediation actions have failed, it will become necessary to inform participants and their families, guardians or representatives that an alternate compliant setting will need to be selected.

The development of the Illinois Statewide Transition Plan was subject to public input, as required at 42 CFR 441.301(6)(B)(iii) and 42 CFR 441.710(3)(iii) and describes the process Illinois utilized for obtaining initial stakeholder input as well as plans to maintain stakeholder dialogue as the Transition Plan is modified.

Illinois assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in the state's approved Statewide Transition Plan (STP). The state will implement any required changes upon approval of the STP and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:
University of Illinois at Chicago, Division of Specialized Care for Children (UIC-DSCC)

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 Medicaid Agency (MA) delegates the day-to-day operations and care coordination of this waiver to the University of Illinois at Chicago, Division of Specialized Care for Children (DSCC), the operating agency (OA). The OA's primary responsibilities are day-to-day care coordination and quality assurance activities. Roles and responsibilities are defined in an interagency agreement (IA). The MA and OA review

the IA at least annually.

The OA delegated responsibilities include: conducting the Level of Care assessment and other assessments; developing the service plan; overseeing health and safety of waiver participants; conducting monitoring of care coordinators, nursing agencies and Home Medical providers; and serving as payer for respite, in-home nursing and other services.

The MA agency oversight of support plans includes the following: 1)The MA selects the representative sample and the OA conducts the reviews of the support plans, as part of their oversight responsibilities. DSCC then submits findings and remediation to HFS. HFS assures compliance with federal and state regulations.

2) Separately, the MA conducts an annual comprehensive desk audit of 20 participants that includes a review of support plans, as well as a phone interview with the family and the care coordinator. Findings are shared with the OA. The OA reviews the findings, initiates any corrective actions and submits a response to the MA.
-
The MA conducts quarterly meetings with the OA to review performance measures and quality assurance outcomes, policy and OA activities as assigned in the IA. The MA conducts annual desk audits of participant records and interviews with waiver participants and families in the sample to evaluate OA performance of required functions and consumer satisfaction with care coordination and services. The MA establishes all rules, rates and policy for this waiver and maintains the appropriation.
-

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.:*
   - ◉ **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:

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:

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
Participant waiver enrollment	☑	☑
Waiver enrollment managed against approved limits	☑	☑
Waiver expenditures managed against approved levels	☑	☑
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☑
Prior authorization of waiver services	☑	☐
Utilization management	☑	☑

Qualified provider enrollment	☑	☑
Execution of Medicaid provider agreements	☑	☑
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☑
Quality assurance and quality improvement activities	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
1A: # and % of quality assurance findings of non-compliance discovered during the OA regional office record reviews with evidence of timely remediation within 60 days. N: # of quality assurance findings of non-compliance discovered during the OA regional office record rev. with evidence of timely remed. within 60 days. D:Total # of quality assurance findings of non-compliance during OA record rev.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
2A: # and % of nursing agency providers with findings of non-compliance related to qualifications with evidence of remediation within 60 days. N: # of NA providers with findings of non-comp. in qualifications/or req. with evid. of remed. w/in 60 days. D: Total # of NA providers with findings of non-comp. related to qual. or other req.

Data Source (Select one):

Other
If 'Other' is selected, specify:
OA Reports

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

Data Aggregation and Analysis:

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

3A: # and % of HME providers with findings of non-compliance related to qualifications with evidence of remediation within 60 days. N: # of HME providers with findings of non-comp. in qualifications/or req. with evid. of remed. w/in 60 days. D: Total # of HME providers with findings of non-comp. related to qual. or other req.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
4A: # and % of nursing agency providers with findings of non-compliance related to program requirements other than qualifications with evidence of remediation within 60 days. N: # of NA providers with findings of nom-compliance with evidence of remediation within 60 days. D: Total # of NA providers with findings of non-compliance.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
5A:# and % of HME providers with findings of non-compliance related to program requirements other than qualifications with evidence of remediation within 60 days. N: # of HME providers with findings of nom-compliance with evidence of remediation within 60 days. D: Total # of NA providers with findings of non-compliance.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
6A: # and % of fiscal estimates where enrollment slots, utilization and expenditures are less than or equal to the estimated levels in the approved waiver. N: # of fiscal estimates of waiver enrollment slots, utilization and expenditures that are less than or equal to estimated levels in approved waiver. D: Total # of fiscal estimates of waiver enrollment slots, utilization and expenditures.

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:
7A; # 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 submitted to the MA.

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:
8A: # and % of nursing agency providers with findings of non-compliance related to OA requirements with evidence of remediation within 60 days. N: # of NA providers with findings of non-comp. in qualifications/or req. with evid. of remed. w/in 60 days. D: Total # of NA providers with findings of non-comp. related to qual. or other req.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
9A: # and % of waiver providers with a Medicaid provider agreement on file. N: # of providers with a Medicaid provider agreement on file. D: Total # of waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS 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 = 95% with 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
10A: % and % of participants' service plans that did not address needs or personal goals as identified in the assessment(s) that were remediated within 60 days. N: # of participants' service plans that did not address needs or personal goals that were remediated within 60 days. D: # of participants' service plans reviewed that did not address needs or personal goals identified in the assessment.

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

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

Data Aggregation and Analysis:

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Upon discovery of any issue or incident that may adversely affect the health and well being of a participant, the OA addresses the issue with the entity and monitors until resolution. Pertinent information is gathered, evaluated, and interventions are taken as needed to protect the health and well being of the participant. The OA may request that staff be removed from the home, agencies placed on "Hold" until remediation is complete and reporting to outside governing agencies is completed if necessary. When an agency is placed on "HOLD", they are prohibited from accepting new participants until remediation is complete and reporting to outside governing agencies is completed. Participants may also be removed from the setting if at risk. The OA reports incidents and interventions to the MA at least quarterly and/or immediately if warranted.

Appendix B:
1A,2A,3A,5A,8A: Upon discovery of non-compliance findings with untimely remediation, the OA requires that the OA regional offices or provider agencies submit a corrective action plans within 60 days for addressing deficiencies and how deficiencies will be prevented in the future. If remediation is not timely, the OA will review procedures and develop a plan of action to monitor to completion.

4A: Upon discovery of non-compliance, the OA will submit the Medicaid provider agreement and the MA will verify that the provider is qualified. If the provider is not qualified, the provider is dis-enrolled and the OA provides participant with other available providers. If a provider agreement cannot be documented, a new provider agreement is obtained.

6A: The MA and OA conduct analysis of previous enrollment, utilization, and expenditure estimates and estimates are revised as necessary. If indicated, an amendment to the waiver is submitted to CMS.

7A: The OA will submit outstanding policies to the MA for approval.

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)			
[x] Aged or Disabled, or Both - Specific Recognized Subgroups					
	[ ]	Brain Injury			[ ]
	[ ]	HIV/AIDS			[ ]
	[x]	Medically Fragile	0		[x]
	[x]	Technology Dependent	0		[x]
[ ] 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:

Individuals under the age of 21 who, because of the severity of their physical illness or disability would require the level of care appropriate to a hospital or nursing facility without the support of the services provided under the waiver. The participants live with families or legally responsible adult(s) in private residences. The waiver participants do not include individuals under 21 who require institutionalization solely because of a severe mental or developmental impairment.

The waiver also includes clients who had been waiver participants up to the day before turning 21 years of age and are now over 21 years of age.

Other criteria: Individuals must meet the minimum score on the Illinois approved level of care (LOC) tool.

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: 125

- ( ) **Other**

Specify:

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

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of

waiver participants. Complete Items B-2-b and B-2-c.

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

- **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

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

    Specify the formula:

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

  Specify percent:

- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

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

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:

The waiver program is designed to support families in providing in home supports to technology dependent children with complex medical needs and to offer ongoing care coordination. Parents or caregivers are required to demonstrate the skills needed to provide all of the participant's care needs prior to beginning home care.

Level of care and other comprehensive assessments will be conducted that identify medical fragility and technology needs; risks; caregiver, educational and social supports; and other available resources, that will be used in developing a participant and family centered support plan. The intensity of the care coordination support is based on the participant's assessed medical needs and other risks.

Families are notified of decisions for services via the HFS 2352 Notice of Decision on Request for Medical Services/Item, to initiate, change or terminate services. The HFS 2352 contains information about the right to appeal and the process to be used. If an appeal is initiated by the date a reduction or discontinuance will occur or within ten

(10) calendar days of the date of the adequate notice, services will be continued at the level in effect prior to the proposed action, pending the results of the fair hearing process, unless the individual specifically requests that his or her services not be continued. The Fair Hearing process is further defined in Appendix F.

-

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

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

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

-
Each participant is assessed on an individual basis to determine whether additional services are needed to serve the participant safely in the home. The need and approval of additional services will be determined by the MA.
-
Families are informed to notify the care coordinator if needs change that may require additional services. If a participant is hospitalized for over 10 days, care coordinators inform the MA of the participant's status. If additional services are needed after discharge, the care coordinator works with the family, nursing agency, the hospital and the MA to arrange for services.

Additional hours of in-home support services may be authorized for up to 60 days by the MA to address short-term unforeseeable events, such as to prevent hospitalizations when the child is acutely ill, or prevent re-hospitalization when a child is recovering from a medical procedure or illness, or to cover a family caregiver emergency if no unpaid caregiver is available.

The OA care coordinators monitor the implementation of the support plan and report problems to the MA as indicated.
-

- [ ] **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	700
Year 2	700
Year 3	825
Year 4	875

Year 5	1015

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

- (●) **The State does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The State limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. **Allocation of Waiver Capacity.**

Select one:

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

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity

and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

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

The waiver provides for the entrance of all eligible persons.

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)**
- [x] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Adult Group 42 CFR 435.119
Former Foster Care Group: Section 1902(a)(10)(A)(i)(IX) of the Act
Parents and Other Caretaker Relatives: 42 CFR 435.110
Pregnant women 42 CFR 435.116
Children 42 CFR 435.118

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: [ ]

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

Select one:

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

Specify percentage amount: [ ]

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.** *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

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

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

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

- ○ **Use spousal post-eligibility rules under §1924 of the Act.** *(Complete Item B-5-c (209b State) and Item B-5-d)*
- ○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)** *(Complete Item B-5-c (209b State). Do not complete Item B-5-d)*

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

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

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

(*select one*):

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

Specify:

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

(*select one*):

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

Specify percentage:

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

Specify dollar amount:

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

Specify percentage: 100

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

Specify:

- The following dollar amount

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

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

Specify:

- Other

Specify:

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

- Not Applicable (see instructions)
- The following standard under 42 CFR §435.121

Specify:

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

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

- The amount is determined using the following formula:

Specify:

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

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

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

- The amount is determined using the following formula:

Specify:

Other
Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

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

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

  (*select one*):

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

    Specify:

    [ ]

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

    (*select one*):

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

      Specify percentage: [ ]

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

      Specify dollar amount: [ ]

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

    Specify percentage: 100

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

    Specify:

    [ ]

- ( ) **The following dollar amount**

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

The following formula is used to determine the needs allowance:

Specify:

Other

Specify:

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

Not Applicable (see instructions)

The following standard under 42 CFR §435.121

Specify:

Optional State supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

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

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

- Other

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

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

Specify percentage: 100

- **The following dollar amount:**

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

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

Specify formula:

○ **Other**

Specify:

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

Select one:

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

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

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

i. **Minimum number of services.**

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

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

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

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

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

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

Specify the entity:

- ○ **Other**

Specify:

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:

Qualifications for Home Care Consultants include one of the following:

Nurse Consultant
•Licensed in Illinois as a registered professional nurse (RN), Bachelor's Degree preferred, and has two years of public health or specialized nursing experience.

Medical Social Consultant
1) Master's degree in Social Work or Social Service Administration, and one of the following:
•Current State of IL Licensure as a Licensed Social Worker or Licensed Clinical Social Worker.
OR
•Two years (24 months) of progressively more responsible full-time experience in social work in a medical/clinical or other social service agency setting.
2) Bachelors of Arts Degree or Science from an accredited college or university in social science, social work or in a related field, AND

•Two years (24 months) of progressively more responsible full-time experience in social work in a medical/clinical or other social service agency setting.

For home care consultants, the OA also utilizes a competency-based training program and a six-month probationary period. If a Home Care Consultant does not meet the OA's expectations, he or she will not be certified.

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

The Illinois MFTD LOC instrument has been developed with assistance of a Quality Improvement Organization (QIO). LOC instruments used by other states were studied. A tool was tested and adopted specific to Illinois from LOC tools used by Oregon and Virginia. The LOC tool assesses both technology and nursing needs (medical fragility). Points are assigned to technology and nursing services. A minimum of 50 points is required. Once completed, the LOC and other medical information is sent to HFS for review and approval. Admission to the waiver will be contingent upon an applicant requiring one or more of the services offered in the waiver in order to avoid institutionalization.

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.

Hospitals:
Illinois contracts with a Quality Improvement Organization (QIO) to provide utilization and quality review in the fee-for-service inpatient hospital setting. The nurse reviewer conducts the initial level of review utilizing the most recent InterQual criteria appropriate for the acute inpatient hospitalization.

Nursing Facilities:
In order to be eligible for waiver services, the customer must be evaluated with Illinois' nursing facility level of care assessment and receive at least the minimally required points established in rule. 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). When scoring the ADLs and the IADLs, the reviewer assesses both the level of impairment and the unmet need for care. 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.

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 same Illinois MFTD LOC instrument that is used for admission to the waiver will also be used for reevaluations for continued eligibility. DSCC care coordinators will perform a LOC review at least annually or when there is signficant change. The LOC will be reviewed by HFS including a review of waiver services utilized to determine the continued need for the 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 uses a report to track initial evaluations and re-evaluations. The report includes the date the LOC was completed, the registration date (physician information and insurance information obtained) and the date the waiver application was submitted to HFS.

It is created monthly and provided to the OA Program Service Managers (PSMs) and HFS. The DSCC Home Care Program Support Unit (HCPSU) also reviews this report and if delays are noted, contacts the appropriate PSM or care coordinator for follow up.

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:

-
Both the MA and the OA maintain evaluations and reevaluations.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
9B: # and % of applicants who met the LOC criteria prior to receipt of services. N: # of applicants who met the LOC criteria prior to receipt of services. D: Total # of newly enrolled MFTD waiver participants.

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

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:
10B: # and % of waiver participants who received a timely annual redetermination of eligibility. N: # of participants that had an annual reassessment within 12 months of the previous eligibility assessment. D: Total # of waiver participants requiring an annual eligibility reassessment.

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

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:
11B: # and % of waiver participants with initial and annual LOC determinations where the LOC criteria was accurately applied. N: # of waiver participants where LOC assessments were completed accurately. D: Total # of waiver participants who had an initial determination or annual LOC redetermination.

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

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

Data Aggregation and Analysis:

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

	Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
9B,10B: When it is discovered that a LOC assessment has been completed, but late, the MA will review timeliness requirements for LOC assessments/reevaluations with the designated entity conducting LOC assessments. The evaluating entity has 30 days to complete the LOC assessment. If eligible, participant services will be initiated or continued. If ineligible, waiver enrollment or participant services will be discontinued, and the participant will be assisted with accessing other supports and services. Adjust federal claim as indicated.

11B: The MA requests that the MA designated entity conducting the LOC assessement review the LOC for accuracy. The MA designated entity has 30 days to resubmit accurate LOC or submit additional medical documentation to support the LOC score. If accurately applied and eligible, initiate or continue services. If inaccurately applied and not eligible, discontinue waiver enrollment and assist with accessing other supports and services. Adjust federal claim as indicated.

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).

-
Parents or guardians are informed of feasible alternatives and given a choice of waiver services or institutional care. The information is provided by the OA care coordinator at the earliest time in the hospital discharge planning process, or in the participant's home. It is explained again during the annual support planning meeting. The final choice, made by the parents or guardian is documented on the HFS 2869, Service Explanation for Medically Fragile, Technology Dependent Children, and is signed by the participant's parents/guardian and the OA care coordinator. The form documents whether the family chooses in home or institutional services.

The signed form also indicates that the family is expected to provide, to the fullest extent possible, direct care to the participant receiving services and that the services approved through the waiver may be revised based on periodic reviews and changes in the medical and home environment needs of the participant. Lastly, it states that the maximum age limit for the waiver is 20 years.

The family chooses the nursing agency and home medical equipment provider and may change service providers at any time. The OA provides a list of all approved providers that serve families in the geographical area to families upon entry into the program, upon request and as the need to change providers arises. The list is continually updated. The parent/legally responsible adult (LRA) and the care coordinator signs the Provider of Service Selection (form 53.43)indicating choice.

When a family requests a change in the provider, the OA care coordinator assists in facilitating the change.
-

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

Copies of freedom of choice documentation are maintained in the participant's case files at the OA.

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):
-
In addition to the assistance provided by the OA for accessing care coordination services through the OA regional offices, the care coordinators assist the families to access nursing and waiver services through the same strategies using bilingual OA staff, bilingual community interpreters, and the State's contracted language line. Potential service providers are apprised of the need to use interpreters or their own bilingual staff for those families with limited English proficiency. The OA also

assists the families in determining the ability of the potential providers in meeting that need.
-

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	Respite
Extended State Plan Service	Specialized Medical Equipment and Supplies
Other Service	Certified Nursing Assistant (CNA)
Other Service	Environmental Accessibility Adaptations
Other Service	Family Training
Other Service	In Home Shift Nursing
Other Service	Medically Supervised Day Care
Other Service	Nurse Training
Other Service	Placement Maintenance Counseling Services

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:**

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

Service Definition *(Scope):*

Provision of care and supportive services to enable the participant to remain in the community, or home-like environment, while periodically relieving the family of care-giving responsibilities.

These services will be provided in the participant's home or in a Children's Community-Based Health Care Center Model, licensed by the Illinois Department of Public Health. If providing respite in the home, respite services will be provided by appropriately qualified licensed nurses and certified nurses aides, employed by an approved private duty nursing agency. If providing respite in the Children's Community-Based Health Care Center Model , nurses and certified nurse aides will be employed by the Center. The State assures that respite and private duty nursing services will not be provided simultaneously.

The Children's Community-Based Health Care Center Model is a designated site which provides necessary technological support and nursing care provided as respite care in a stand-alone facility. As a participant in a demonstration program under the Alternative Health Care Delivery Act, it is licensed by the Illinois Department of Public Health as an Alternate Health Care Model. The model provides respite for a period of one to 14 days for those individuals, under age 21, who are in the Medically Fragile and Technology Dependent Waiver, and who are clinically stable. Care is to be provided in a home-like environment that serves no more than 12 children at a time, offering an alternative setting for waiver services normally provided in the child's home. Transportation to and from the respite care center is the responsibility of the parent(s). HFS provides no reimbursement for educational services provided to a child while receiving services at the respite care center. For the purpose of this waiver, authorization of respite services at the children's respite care center requires: prescription by the physician managing care; request by the child's parent(s) and/or guardian; and the child is an approved waiver recipient, under age 21, and clinically stable.

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.
-

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Respite care services will be limited to a maximum of 14 days or 336 hour annual limit. Exceptions may be made on an individual basis based on extraordinary circumstances.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Approved Nursing Agency
Agency	Children's Community-Based Health Care Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Approved Nursing Agency
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Meet DSCC nursing agency requirements-DSCC Home Care Manual, 53.09

Verification of Provider Qualifications

Entity Responsible for Verification:
DSCC

Frequency of Verification:
Upon enrollment and biennially

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency

Provider Type:
Children's Community-Based Health Care Center

Provider Qualifications

License *(specify)*:
77 ILAC 260

Certificate *(specify)*:

Other Standard *(specify)*:
Meet DSCC annual renewal requirements for Children's Community-Based Health Care Center

Verification of Provider Qualifications

Entity Responsible for Verification:
DSCC verifies that the Children's Community-Based Health Care Center is licensed and that they meet the DSCC annual renewal requirements. DSCC also conducts annual onsite visits.

The Department of Public Health licenses the model.

Frequency of Verification:
DSCC verifies annually.

DPH verifies 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:
Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
This service is the provision of equipment or supplies needed to maintain a participant in the home and the coverage of operational and maintenance costs of equipment, not otherwise available through the State Plan or through other third party liability.

Medical supplies, equipment and appliances are provided only on the prescription of the primary care physician as specified in the plan of care. Since each home care waiver case addresses a unique set of needs, provision of an all-inclusive list is not possible. Therefore, the State assures that these services will only be provided to meet the medical, health and safety needs of the participant. These will be limited in scope to the minimum necessary to meet the participant's needs and will be utilized in accordance with manufacturer's suggested standards.

This service differs from that offered under the State Plan in that it includes operational and maintenance costs for equipment. (Maintenance costs are incurred only for Medicaid agency leased or family owned equipment not otherwise available under the State Plan.)
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
There is a $25,000 maximum per participant per five-year period for any combination of Environmental Accessibility Adaptations and Specialized Medical Equipment and Supplies. The approval for this service is subject to prior approval by the MA.

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Approved Medicaid Medical Equipment or Infusion Provider
Agency	Other Medicaid provider

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Approved Medicaid Medical Equipment or Infusion Provider

Provider Qualifications

License *(specify):*

225 ILCS 51

Certificate *(specify):*

Other Standard *(specify):*

If not licensed under 225 ILCS 51, must be accredited by the Joint Commission on Accreditation of Healthcare Organizations, or other accrediting organization.

Meet the OA Home Medical Equipment requirements for the waiver

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

The OA verifies upon enrollment and annually that provider is licensed or accredited. The OA monitors annually through onsite visits or desk audits to ensure compliance with OA HME requirements.

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Other Medicaid provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A Medicaid enrolled pharmacy or durable medical equipment provider that provides items not available from an OA approved home medical equipment (HME) provider,(such as special formula).

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

Frequency of Verification:

At time of service

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:

Certified Nursing Assistant (CNA)

HCBS Taxonomy:

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

Service Definition *(Scope):*

The Certified Nursing Assistant (CNA) service 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. 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:

CNA services require a prescription from a physician stating that the individual requires CNA services in the

home. Other documents required include: medical reports, and reports of hospitalizations. The amount, duration and/or frequency of these services are dependent on continued authorization by the physician, and an independent assessment of medical necessity by the Medicaid agency or its designee.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DSCC Approved Nursing Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Certified Nursing Assistant (CNA)

Provider Category:
Agency

Provider Type:
DSCC Approved Nursing Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Meet requirements for Nursing Agencies Participating with the Illinois Department of Healthcare and Family Services Home Care Program DSCC Home Care Manual 53.09

Verification of Provider Qualifications

Entity Responsible for Verification:
DSCC

Frequency of Verification:
Upon enrollment and biennially

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:**

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

Service Definition *(Scope)*:
-
Those physical adaptations to the home or family vehicle required by the participant's plan of care, which are necessary to ensure the health, welfare and safety of the participant, or which enable the participant to function with greater independence in the home or community, and without which, the participant would require institutionalization. Such adaptations may include the following: telephone installation; exterminations of disease vectors; minor carpentry around windows and doors to reduce drafts; house lifts (in those situations where a ramp is not possible) the installation of ramps and grab-bars; widening of doorways; modifications of bathroom facilities; installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the participant; or vehicle modification. 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 participant, such as carpeting, roof repair, central air conditioning. 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.

The State assures that all environmental modifications will only be provided to meet the medical necessity of the participant. They will also be limited in scope to the minimum necessary to meet the participant's medical needs. This service is not otherwise covered in the State Plan.
-
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
-
There is a $25,000 maximum per participant per five-year period for any combination of Environmental Accessibility Adaptations and Specialized Medical Equipment and Supplies. The approval for this service is subject to prior approval by the MA.

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

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

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

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	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:
Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The OA's DSCC Home Care Manual, 53.20.30, (Rev.9/01) &53.43 (Rev.9/01)

Verification of Provider Qualifications

Entity Responsible for Verification:
OA Care Coordinators

Frequency of Verification:
At the time that the service is requested

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:
Family Training

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:
Training for the families of participants served on this waiver. For purposes of this service, family is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse,siblings, relatives, foster family, in-laws or person designated by the family to be a back-up caregiver. Family does not include individuals who are employed to care for the participant. Training includes instruction about treatment regimens and use of equipment specified in the plan of care and shall include updates as necessary to safely maintain the participant at home. It may also include training such as Cardiopulmonary Resuscitation (CPR). All family training must be included in the participants written plan of care. This service is not covered in the State Plan.

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**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OA Approved Nursing Agency
Individual	Approved Service Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Family Training

Provider Category:
Agency

Provider Type:
OA Approved Nursing Agency

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Meet the OA nursing agency requirements-DSCC Home Care Manual, 53.09

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

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: Family Training

Provider Category:

Individual

Provider Type:

Approved Service Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Qualify to provide the service. (For example, American Red Cross or American Heart Association for CPR)

Verification of Provider Qualifications

Entity Responsible for Verification:

OA

MA

Frequency of Verification:

At time of service

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:**

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

Service Definition *(Scope):*
The waiver provides in-home shift nursing to adults (age 21 and over) as this service is not covered in the Illinois State plan. 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. These services are provided by RNs and LPNs that meet Illinois licensure standards for nursing services. Services can also be provided by CNAs. RNs, LPNs, and CNAs may only provide services authorized through their licensure type. Services may include the following.

Registered Nurses may provide and coordinate care, educate the participant and the public 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.

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.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
In-home shift nursing services require a prescription from a physician stating that the individual requires shift nursing services in the home. Other documents required include: medical reports, and reports of hospitalizations. The amount, duration and/or frequency of these services are dependent on continued authorization by the physician, and an independent assessment of medical necessity by the Medicaid agency or its designee.

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DSCC Approved Nursing Agency

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:
DSCC Approved Nursing Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Meet Requirements for Nursing Agencies Participating with the Illinois Department of Healthcare and Family Services Home Care Program DSCC Home Care Manual, 53.09
Verification of Provider Qualifications
Entity Responsible for Verification:
DSCC
Frequency of Verification:
Upon enrollment and biennially

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:
Medically Supervised Day Care

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*

-

This service offers the necessary technological support and nursing care provided in a licensed medical day care setting as a developmentally appropriate adjunct to full time care in the home. Medically supervised day care serves to normalize the child's environment and provide an opportunity for interaction with other children who have similar medical needs. This service is not covered in the State Plan.

Such services are to be an alternative to otherwise necessary private duty nursing services in the home and are to include required safe and supervised transport between the home and day care center, while school age children may utilize day care facilities, HFS provides no reimbursement for education services nor is it part of the rate methodology for day care facilities. For purposes of this waiver, authorization of day care services requires: a prescription by the physician managing medical care; a request by the child's parent(s) and/or legal guardian; the use of a facility licensed by the State to provide day care services and assurances of staffing ratios that are at least one licensed staff nurse for each three children.

-

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

-

Maximum of 12 hours per day, five days per week.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Children's Community-Based Health Care Center Model

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medically Supervised Day Care

Provider Category:

Agency

Provider Type:

Children's Community-Based Health Care Center Model

Provider Qualifications

License *(specify):*

77 ILAC 260

Certificate *(specify):*

N/A

Other Standard *(specify):*

Meet the OA annual renewal requirements for Children's Community-Based Health Care Center

Verification of Provider Qualifications

Entity Responsible for Verification:

The OA veifies that the Children's Community-Based Health Care Center is licensed and that they meet the OA annual renewal requirements. DSCC also conducts annual onsite visits.

The Department of Public Health licenses the model.
Frequency of Verification:
The OA verifies waiver participation requirements, annually

DPH verifies licensure requirements 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:
Nurse Training

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:
This service provides child specific training for nurses, under an approved nursing agency, in the use of new or unique prescribed equipment, or special care needs of the child. This service is not covered in the State Plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Maximum of four hours per nurse, per waiver year.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	OA Approved Nursing Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nurse Training

Provider Category:
Agency
Provider Type:
OA Approved Nursing Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The OA Nursing agency requirements-DSCC Home Care Manual, 53.09.
Verification of Provider Qualifications
Entity Responsible for Verification:
OA
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:
Placement Maintenance Counseling Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope)*:
This service provides short-term, issue-specific family or individual counseling for the purpose of maintaining the participant in the home placement. This service is prescribed by a physician based upon his or her judgment that it is necessary to maintain the child in the home placement. This service must be provided by a licensed clinical social worker (LCSW), a licensed clinical psychologist (LCP), or an agency certified by the Department of Human Services, Division of Mental Health or Department of Children and Family Services to provide Medicaid Rehabilitation Option services. The service provider must accept MA payment, as payment in full, and provide services in the home if the participant or participant's family is unable to access services outside the home. This service is not covered in the State Plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services will require prior approval by the MA and will be limited to a maximum of twelve sessions per calendar year.

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Licensed Clinical Psychologist
Individual	Licensed Clinical Social Worker
Agency	Medicaid Rehabilitation Option

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Placement Maintenance Counseling Services

Provider Category:
Individual
Provider Type:
Licensed Clinical Psychologist
Provider Qualifications
License *(specify)*:
225 ILCS 15
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
The OA obtains the license and sends to HFS in a request for approval

The MA reviews the license for the prior approval of the service
Frequency of Verification:
Upon enrollment for each service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Placement Maintenance Counseling Services

Provider Category:
Individual
Provider Type:
Licensed Clinical Social Worker
Provider Qualifications
License *(specify)*:
225 ILCS 20
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
The OA obtains the license and sends to HFS in the request for approval.

The MA reviews to verify for prior approval of the service.
Frequency of Verification:
Upon enrollment for each service

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Placement Maintenance Counseling Services

Provider Category:
Agency
Provider Type:
Medicaid Rehabilitation Option
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
59 Illinois Administrative Code Part 132, Medicaid Rehab Option
Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
The OA verifies that the provider is certified by the Illinois Department of Human Services

The MA verifies the certification as part of the prior approval for the service.
Frequency of Verification:
Upon enrollment and for each service

Appendix C: Participant Services

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

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☑ **As an administrative activity.** *Complete item C-1-c.*

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

OA care coordinators conduct case management functions on behalf of waiver participants.

The OA is the Title V CSHCN (Children with Special Health Care Needs) agency for Illinois providing care coordination for families and children with special health care needs. The OA's experience with children with special health care needs dates back to 1937. The OA's Home Care program was established in 1985 when the MFTD waiver was initially approved. Services are coordinated by a network of professional staff located in 13 regional offices throughout the state.

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):

-
Nursing agencies, Medically Supervised Day Cares and the Children's Community-Based Health Care Centers are responsible, under a signed agreement with the OA, for complying with the Health Care Worker Background Check Act. The Act requires that the agencies cannot knowingly hire persons in the position of providing direct

care who have a history of criminal conviction for specified crimes as listed in the Act. Criminal Background checks must be completed through the Illinois State Police (ISP) database as a condition of hire for certified nurse aides (CNA) providing care to the participants in the waiver. Licensed Professionals, including nurses are currently excluded from the Health Care Worker Background Check Act.

The OA verifies during the annual onsite reviews at the nursing agencies that a criminal background check was done for CNAs providing care to the participant selected in the sample.
-

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):

-
By statute, the Illinois Department of Children and Family Services (DCFS) maintains the State's child abuse and neglect registry. The registry is called the Child Abuse and Neglect Tracking System, or CANTS.

The Illinois Department of Public Health (DPH) maintains a central Health Care Worker Registry. This Registry is an expansion of the former Illinois Nurse Aide Registry. Nursing agencies, Medically Supervised Day Cares and Children's Community-Based Health Care Centers are required to check the DPH Health Care Worker Registry prior to hiring certified nurse aides (CNAs) to provide services in the waiver. This action is listed on the Requirements forms for each of these provider types.

Nursing agencies are required to complete registry checks on all employees. Employees cannot be hired if they fail the DPH or CANTS registry checks. The results of the registry checks are documented by the provider in the employee's file.

The OA annually receives a list of licensed nurses and CNAs employed by the agencies. The OA verifies that the CNAs are certified and have no disqualifying convictions. The OA annually verifies the license and sanction status of all nurses caring for the participants in the waiver through web links managed by the Department of Financial and Professional Regulations, Office of Inspector General (OIG), and the Health and Human Services Exclusion list.

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible

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

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

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

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

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

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

- ( ) **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:

Any willing and qualified provider may request to be enrolled in the waiver program. Providers may contact the OA through any of their offices or go through the OA web site to request information about the requirements and procedures to qualify. There are no specific timeframes for qualifying or enrolling.

Providers enter the program in a number of ways:
• Provider may contact the OA regional office.
• Family may request a specific provider. The family may already be working with a nursing agency or home medical supplier, or they may request a specific provider.
• The OA regional office may recruit nursing agencies, home medical equipment providers or other providers.

Approved Nursing Agency

The OA approved nursing agencies listed in Appendix C as Provider Types for waiver services, Respite, Nurse Training and Family Training, are the same as those approved to provide in home shift nursing to eligible children in the waiver.

For those nursing agencies, once the contact is initiated, the care coordinator is responsible for introducing the waiver program. The care coordinator arranges a meeting with the nursing agency administrative personnel to explain the program.

The OA care coordinator requests the OA Home Care Program Support Unit (HCPSU) to begin the approval process. HCPSU provides the nursing agency a copy of the participation requirements and completes an interview questionnaire with the agency. The OA also sends an approval packet to the agency that requests the required documents, including evidence of license and professional insurance, and provides Medicaid enrollment forms if not already enrolled.

If approved, the OA HCPSU sends a letter of approval to the agency and notifies by e-mail all regional offices in the agency's geographic service area. If enrollment is denied, the OA HCPSU sends the agency and the Medicaid agency Provider Participation Unit a letter documenting the reason for denial. Nursing agency approval is renewed annually using basically the same application packet.

Home Medical Equipment (HME) Providers

The OA sends an approval packet to the HME supplier requesting information. HME providers must be enrolled in the Medicaid program and meet the requirements for participation. HMEs must complete a general information sheet initially and every other year.

If approved, the OA HCPSU sends a letter of approval to the HME provider and notifies by e-mail all regional offices in the agency's geographic service area. If enrollment is denied, the OA HCPSU sends the HME and the Medicaid agency Provider Participation Unit a letter documenting the reason for denial. HME provider approval is renewed annually using basically the same application packet.

Other Providers:

Families or care coordinators can identify other providers that can provide environmental modifications. This might include electrical modifications, providers that install lifts or ramps, or carpenters that widen doorways. The providers are responsible for obtaining appropriate permits and submitting their bill to the care coordinator. The provider must be enrolled and provide tax identification information and proof of insurance.

Any interested provider can contact the OA through any of their offices or the OA web site to request information about the requirements and procedures to qualify. There are no specific timeframes for qualifying or enrolling."

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Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. **Methods for Discovery: Qualified Providers**

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
12C: # and % of nurses who meet license standards prior to serving waiver participants initially receiving nursing services from the agency. N: # of nurses who meet licensing standards prior to serving waiver participants initially receiving NS from the agencies. D: # of nurses reported by the agencies who are assigned to waiver participants initially receiving NS from the agencies.

Data Source (Select one):
Other
If 'Other' is selected, specify:
List of nurses submitted by nursing agencies at the start of the case

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

Performance Measure:
13C: # and % of nurses that continue to meet license standards at redetermination. N: # of nurses that continue to meet license standards at redetermination. D: All nurses reported by nursing agencies to be providing services to enrolled waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
List of nurses submitted by nursing agencies at the annual renewal

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:
14C: # and % of nursing agencies that meet DPH license standards, initially and ongoing. N: # of nursing agencies that meet DPH licensure requirements initially and ongoing. D: All enrolled nursing agencies.

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

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

Performance Measure:
15C: # and % of placement counselor providers that meet license standards, initially and ongoing. N: # of placement counselor providers that meet licensure requirements initially and ongoing. D: All enrolled placement counselor providers.

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

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

Performance Measure:
16C: # and % of HME providers that meet license or certification standards, initially and ongoing. N: # of HME providers that are licensed or certified initially and ongoing. D: All enrolled HME providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
IDFPR or Accreditation Agency Website

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: 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**	☑ **Annually**

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

Performance Measure:
17C: # and % of Children's Community-Based Health Care Center Model that meet license standards, initially and ongoing. N: # of Children's Community-Based Health Care Center Model that are licensed initially and ongoing. D: All enrolled Children's Community-Based Health Care Center Model providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
IDPH Website and MA 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: Initially	

Data Aggregation and Analysis:

Responsible Party for data	**Frequency of data aggregation and**

aggregation and analysis *(check each that applies):*	**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.

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:
18C: # and % of nurses, serving waiver participants, who have a current CPR certification. N: # of nurses, serving waiver participants who have a current CPR certification. D: All nurses serving waiver participants in representative sample.

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

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

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with 5% margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
19C: # and % of nurses, serving waiver participants, that have completed the DCFS Online Training for Mandated Reporters. N: # of nurses serving children

who have completed the DCFS Online Training for Mandated Reporters. D: All nurses serving waiver participants in representative sample.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
20C: # and % of nurses, serving waiver participants, with documentation of client specific training. N: # of nurses serving children with documentation of client specific training. D: All nurses serving waiver participants in representative sample.

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

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

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
12C,13C: If the OA finds evidence that the nurse is not licensed or has adverse actions against the license, other than for a student loan violation, the agency is contacted right away. The OA requires nursing agencies to remove unlicensed nurses or nurses with actions against their licenses from waiver cases. If licensure documentation is submitted, nurses may continue to serve waiver participants. If a pattern of non-compliance is a systemic issue within the agency, adverse actions may be applied.

14C: 1) If at initial license check the nursing agency does not meet this requirement, it is not enrolled and is notified that it cannot serve children on the waiver until it becomes licensed. 2) If nursing agency is enrolled and loses its license, it is made inactive, disenrolled and waiver participants are provided the choice of another agency.

15C: 1) If at initial license check the provider does not meet this requirement, he/she is not enrolled and is notified that it cannot serve children on the waiver until he/she becomes licensed. 2) If provider is enrolled and loses his/her license, he/she is made inactive, disenrolled and waiver participants are provided the choice of another provider.

16C: 1) If at initial license and certification check the HME agency does not meet this requirement, it is not enrolled and is notified that it cannot serve children on the waiver until it becomes licensed. 2) If the HME agency is enrolled and loses its license, it is made inactive, disenrolled and waiver participants are provided the choice of another agency.

17C: 1) If at initial license check the Children's Community-Based Health Care Center does not meet this requirement, it is not enrolled and is notified that it cannot serve children on the waiver until it becomes licensed. 2) If the agency is enrolled and loses its license, it is made inactive, disenrolled and waiver participants are provided choice of another agency.

18C: OA requires that nursing agencies submit documentation of CPR certification within 30 days of notification. OA verifies receipt of CPR certification. If not received, within 30 days, OA follows-up with nursing agency and tracks until fully compliant. If not compliant, nurse cannot serve waiver participants. If systemic issue within agency, adverse actions may be applied.

19C: OA requires that nursing agencies submit documentation of DCFS Online training completion within 30 days of notification. OA verifies receipt of training completion. If not received within 30 days, OA follows-up with nursing agency and tracks until fully compliant. If not compliant, nurse cannot serve waiver participants. If systemic issue within agency, adverse actions may be applied.

20C: OA requires that nursing agencies submit documentation of client specific training completion within 30 days of notification. OA verifies receipt of client specific training completion. If not received within 30 days, OA follows-up with nursing agency and tracks until fully compliant. If not compliant, nurse cannot serve waiver participants. If systemic issue within agency, adverse actions may be applied.

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.

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.

All services provided in this waiver, with the exception of Medically Supervised Day Care, are delivered to individuals in

their home settings which are presumed to be integrated. The same rules mentioned above as they relate to residential and non-residential settings are non-applicable and do not require any action by the State.

There are currently no providers approved to deliver Medically Supervised Day Care. Any new service provider or setting must fully comport with the federal home and community-based (HCB) settings rule. The state will ensure that prior to approval of any provider for this service, it will evaluate the setting consistent with the manner specified in the Statewide Transition Plan for the HCB settings rule and that this service will be monitored for compliance with the rule at any amendment or renewal of this waiver.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individual 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:

Qualifications for Home Care Consultants include one of the following:

Nurse Consultant
•Minimum Bachelor's Degree, and
•Licensed in Illinois as a registered professional nurse (RN), and
•Two years of public health or specialized nursing experience

Medical Social Consultant
•Master's degree in Social Work or Social Service Administration, and one of the following:
•Current State of IL Licensure as a Licensed Social Worker or Licensed Clinical Social Worker.
OR
•Three years (36 months) of progressively more responsible full-time experience in social work in a medical/clinical or other social service agency setting.

Speech/Hearing Consultant
•Master's degree in Speech-Language Pathology, Audiology, or Communication Disorders, and
•Two (2) years of experience planning and developing speech and hearing programs that included one year of clinical practice (clinical fellowship year)

Respiratory Therapist III
•Graduation from a two-year training program for respiratory therapists accredited by the AMA Committee on Allied Health Education and Accreditation (CAHEA) or one supported by the Committee on Accreditation for Respiratory Care (CoARC)
OR
•Successful completion of an accelerated post-Baccalaureate program for respiratory therapists accredited by the AMA Committee on Allied Health Education and Accreditation (CAHEA) or one supported by the Committee on Accreditation for Respiratory Care (CoARC), and
•Registration as a Registered Respiratory Therapist (RRT) by the National Board for Respiratory Care, and
•Licensure as a Respiratory Care Practitioner (R.C.P.) by the State of Illinois.

- [ ] **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.

-

Support planning is conducted jointly with the family and participant, the OA care coordination team and others as designated by the family. The care coordinator will assist the family to access needed waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source. The family and participant will guide the support plan and utilization of services based on their preferences and goals.

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) Who develops the plan, who participates in the process, the timing of the plan:

Support planning is conducted at least annually, and as needed based on a change in participant needs. Support planning is conducted jointly with the family and participant, the OA care coordinator and others as designated by the family.

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

The support plan will be based on comprehensive assessments of the participant's needs, including medical, cognitive, communication, therapy, and counseling; participant risks; caregiver, educational and social supports; and other available resources. In addition, OA care coordinators conduct an initial home assessment upon admission to the waiver; at the annual evaluation; or if the family relocates. The home assessment is performed in order to identify safety risks and home modification needs.

Based on the assessments, the care coordinator will meet with the participant and family to develop a plan of support that may, in addition to waiver and other Medicaid services, include referrals, education or training, and/or interventions to meet established needs and goals. Support plans and service utilization are guided by family and participant's preferences and goals.

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

The OA provides information about waiver eligibility and services at intake as part of the application packet. This information is also available at the OA website: www.uic.edu/dscc.

The OA care coordinator discusses available waiver services and other resources with the family and participant during the comprehensive assessment and support planning process.

d) How the plan development process ensures that the service support plan addresses the participant's goals, needs (including healthcare needs, and preferences):

The OA care coordinator conducts a comprehensive assessment. The OA care coordinator works with the family to identify how assessed needs can be supported by waiver and non-waiver services. Support plan development is based on participant needs and guided by the family and participant’s preferences and goals.

e) How the waiver and other services are coordinated;

The OA care coordinators identify and assist the family to access community resources to meet the participant and family's needs beyond waiver services. Care coordinators assist with locating and scheduling of nursing services, and making referrals for other needed services. Care coordinators also participate in Individual Education Plans (IEP) meetings, if the family wants support.

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

The assignment of responsibilities is included in the support plan. The OA care coordinators monitor implementation of the support plans. The intensity of care coordination will be based on assessed risk and support needs.

The approved nursing agencies are responsible to conduct nursing supervisor home visits every 60 days to monitor provision of nursing services. These reports are shared with the OA care coordinators.

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

Participants are reassessed and support plans are updated at least annually and as indicated based on a change in participant status or need. For example, families are informed to call the care coordinator if the child becomes acutely ill and the physician has requested an increase in nursing services. For example, if a participant is hospitalized for over 10 days, care coordinators inform the MA or designated entity of the participant’s current status. If additional services are needed after discharge, the care coordinator works with the family, nursing agency, the hospital and the MA to arrange the services.
-

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.

-
Risk assessment criteria are incorporated into the assessment process. Support plan development will include specific risk mitigation strategies to address assessed risks, and may include more intense care coordination when indicated. This will provide additional monitoring and support, and evaluate the effectiveness of risk mitigation strategies. The families will be included in the discussion of risks and development of the plan.

Multiple sources and mitigation strategies are used to identify and mitigate potential risks. For example, in addition to information obtained from the family, the care coordinator may obtain a social service assessment from the discharging hospital. Risk factors considered include the medical fragility and care needs of the child; the availability and skill levels of parents and other unpaid trained caregivers; past history of abuse, neglect or non-compliance with recommended care; the family's ability to maintain utilities necessary for the participant to be safe in the community; and other factors that affect the caregiver's ability to provide safe care to the child. Waiver services or referral to other resources or supports may be offered to the family, based on the assessed needs and preferences.

Parents or caregivers are required to demonstrate the skills needed to provide all of the participant's care needs prior to beginning home care. After the participant is discharged to home, the nursing agency assesses whether additional caregivers can demonstrate the care skills prior to leaving the child in the care of that person. Training of additional care givers for back up or retraining of back up caregivers may be a risk strategy.

Mitigation strategies required for all support plans include ensuring that local utility and emergency services are notified that a child with special health care needs is in the community. Upon discharge to home, the OA care coordinator assists the family to initiate an emergency phone list. It includes the names and phone numbers of the care coordinator, nursing agency, equipment provider, utility companies, trained caregivers available for back-up, and the Department of Children and Family Services hotline and other resources.

To provide ongoing monitoring of adequacy and implementation of the plans, the nursing agency supervisors visit the participant's home every 60 days and send a summary report, including any changes or concerns, to the OA care coordinators. The nursing agency and HME provider are required to notify the care coordinator if the child is harmed or potential harm may have occurred. Providers are also mandated reporters of suspected abuse or neglect.

If the family indicates that services are not being covered, several options are discussed, such as training additional unpaid caregivers, changing the nursing agency or a short term stay at an alternative care model facility until adequate coverage is secured. Plans for short term hospitalization may be a last resort if no other options are available.

The OA reviews a statistically representative sample of service support plans, including risk mitigation strategies, and care coordination records annually, to identify trends that indicate a need for retraining or changes in process.
-

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The family or participant chooses the nursing agency and HME provider and may change service providers at any time. The OA provides a list of all approved providers that serve families in the geographical area to families upon entry into the program, upon request and as the need to change providers arises. The list is continually updated.

The family/participant indicates choice was given by completing Provider of Service Selection Form. The form is

signed by the family/participant and the care coordinator. If the family does not choose a provider on the approved provider list, the OA explains to them that the provider will not be reimbursed by the State for services. This is option that is listed on the provider selection form.

The OA approved nursing agencies listed in Appendix C as Provider Types for waiver services, Respite, Nurse Training and Family Training, are the same as those approved to provide in home shift nursing to eligible children in the waiver. The nursing agency chosen by the family is contacted to determine whether they are willing to provide the service and able to meet the needs of the child and family.

As part of the selection process, the family is able to review the questions and information provided by the nursing agencies regarding their experience and the services they provide. The family is assisted by the OA care coordinator with the interview process if requested.

Families may choose to change nursing agencies or home medical equipment providers for a number of reasons. The OA care coordinators make every effort to personally assist families to find a nursing agency or home medical provider to meet their needs.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The OA is responsible for monitoring and reporting the performance measures related to support plan development and implementation. The MA and OA meet quarterly to discuss quality outcomes. The MA conducts an annual desk audit from a statewide random selection of participants. The desk audit includes a review of level of care, support plans, and delivery of waiver and non-waiver services, and a comprehensive interview with the family caregivers regarding services and supports. In addition, the MA annually conducts validation reviews of a sample of comprehensive assessments and support plans to ensure assessed needs and preferences are addressed.

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:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

-
The OA care coordinator is responsible for monitoring the implementation of the service support plan and participant health and welfare. The intensity of care coordination is participant centered and based on assessed risks and support needs. The frequency of face-to-face visits and other types of contacts will be individualized based on the risk assessment; however, at a minimum, monthly contacts will be made. Families are informed to notify the care coordinator if needs change that may require additional services.

If, during the regular family contacts, the family indicates that services are not being covered, several options are discussed, such as training additional unpaid caregivers; changing the nursing agency; or a short term stay at an alternative care model facility until adequate coverage is secured. Plans for short term hospitalization may be a last resort option if no other options are available."

Nursing agency supervisors visit the participant's home every 60 days and send a summary report, including any changes or concerns, to the OA care coordinators for review. The summary includes a report of the number of nursing hours provided to the child and any hospital visits.
-
The OA care coordinators conduct multidisciplinary staffing at least annually. Part of their discussion with families covers free choice of providers and how to access non-waiver services. The OA's care coordinator supervisor and/or the OA's Home Care Compliance and Audit Unit regularly review service plans, documentation of family contacts, and nursing agency supervisory reports, and verify that the care coordinators discuss freedom of choice of providers and/or appropriate non-waiver services with the family, such as utility resources.
-
The OA reviews a statistically representative sample of participant support plans annually and the reviews include family interviews regarding service implementation and satisfaction. Results are shared with the MA during quarterly quality improvement meetings.
-
MA conducts comprehensive interviews with family caregivers during the annual desk audit of a random selection of participants. The desk audit includes a review of waiver and other services, such as nursing, home medical equipment and supplies and services provided through the school.
-

b. **Monitoring Safeguards.** *Select one:*

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
21D: # and % of participants who had service plans that addressed needs, including health, safety, and risk factors and personal goals identified in the assessment(s). N: # of service plans that address needs identified in the assessment. D: Total # of service plans reviewed.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
22D: # and % of participants with Service Plans that include emergency plans for medical emergencies or natural disasters including the list of trained caregivers. N: # of participants with service plans that include emergency plans. D: Total # of participants' service plans reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with 5%

		margin of error
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:
23D: # and % of participants' service plans that were developed by persons as specified in the waiver. N: # of participants' service plans that were developed by persons as specified in the waiver. D: # of participants' service plans reviewed.

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

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

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

Performance Measure:
24D: # and % of waiver participants who had their service plan updated annually. N: # of waiver participants who had their service plan updated annually. D: Total # of waiver participants due for an annual renewal.

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

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:
25D: # and % of participants' service plans that were updated or revised when warranted by changes in participant's needs. N: # of waiver participants who had a revised service plan warranted by changes in the participant's needs. D: # of waiver participants identified who had needs that warranted a change in the service plan.

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

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☑ **Other** Specify: Subset Based on Those Where Needs Changed
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: 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:
26D: # and % of participants who received services in accordance with the service plan. N: # of participants who received services in accordance with the plan. D: Total # of participants reviewed.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
27D: # and % of participants who received case management contacts in accordance with the service plan. N: # of participants who received case management contacts in accordance with the service plan. D: Total # of participants reviewed.

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

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

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
28D: # and % of eligible participants offered choice between waiver and institutional care, initially and annually. N: # of participants offered choice between waiver and institutional care. D: Total # of waiver participants in representative sample.

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

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

		Confidence Interval = 95% with 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Initially and every three 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:
29D: # and % of eligible participants offered choice between and among waiver services and providers. N: # of participants offered choice between and among waiver services and providers. D: Total # of waiver participants in representative sample.

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

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

(check each that applies):		
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% with 5% margin of error
☐ **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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
21D,23D,25D,27D: The OA requires that the regional office submit a corrective action plan within 30 days for addressing the deficient records and how deficiency will be prevented in the future. The corrective action plan must indicate that each of the non-compliant individual service plans are revised to remediate non-compliance. The OA follows-up with the OA regional office and tracks until fully compliant. If not compliant, the OA will provide additional training or technical assistance. Trends are tracked to determine if there are systemic issues that need to be corrected.

22D:OA requires that the nursing agency submit a corrective action plan for addressing the deficient records and how this deficiency will be prevented in the future. The corrective action plan must indicate that each of the individual service plans are revised to address emergency plans. OA follows-up with the nursing agency and tracks until fully compliant. If not compliant, OA will provide additional training or technical assistance.

24D: The MA notifies the OA of the overdue service plan. The OA has 30 days to provide the service plan to the MA, who then reviews and approves the service plan.

25D: The OA has 30 days to provide the revised service plan to MA, who then reviews and approves.

26D: The OA requires that the OA regional office submit a corrective action plan to address services provided that were inconsistent with the service plan and how this inconsistency will be prevented in the future. The corrective action plan must indicate how participants will receive services in accordance with the service plan. The OA follows-up with the OA regional office and tracks until fully compliant. If not compliant, the OA will provide additional training or technical assistance.

27D: In addition to the above, the corrective action plan must indicate how the case manager will assure compliance with participant contacts.

28D: The OA requires that the OA regional office submit a corrective action plan for addressing the deficient records and how this deficiency will be prevented in the future. The corrective action plan must indicate that choice will be provided and the form will be signed by the participant's family. The OA follows-up with the OA regional office and tracks until fully compliant. If not compliant, the OA will provide additional training or technical assistance.

29D: OA requires that the regional office submit a corrective action plan for addressing the deficient records and how this deficiency will be prevented in the future. The corrective action plan must indicate that choice was provided and the form was signed by the participant's family. OA follows-up with the regional office and tracks until fully compliant. If not compliant, OA will provide additional training or technical assistance.

ii. Remediation Data Aggregation

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

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

- [ ] **Continuously and Ongoing**
- [ ] **Other**
  Specify:

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

- (●) **No**
- ( ) **Yes**
  Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

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

- ( ) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- (●) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

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

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

- ( ) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal

representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Participants (or his or her legal representative) are informed by the OA care coordinator of appeal rights when eligibility criteria for the waiver is not met, waiver services are initiated and also upon notice of service denial, termination, or reduction. The MA makes final decisions on waiver program eligibility and the Department of Human Services (DHS) makes decisions on financial eligibility. Families are notified of decisions for services via the HFS 2352 Notice of Decision on Request for Medical Services/Item, to initiate, change or terminate services. The HFS 2352 contains information about the right to appeal and the process to be used. If an appeal is initiated by the date a reduction or discontinuance will occur or within ten (10) calendar days of the date of the adequate notice, services will be continued at the level in effect prior to the proposed action, pending the results of the fair hearing process, unless the individual specifically requests that his or her services not be continued. If the date the reduction or discontinuance will occur or the 10th calendar day is a Saturday, Sunday or a holiday, the client has until the end of the next work day to file his/her appeal. To assure that families are informed of this right, the MA notification of benefits for the waiver includes information about the continuation of services pending the outcome of an appeal. The HFS 2352 form is maintained at both the MA and the OA and kept in the waiver participant's file.

DHS reviews financial eligibility and uses a form letter to notify families of their decision to approve or deny services based on financial eligibility requirements. This letter also includes appeal rights. If the OA Care Coordinator becomes aware that the family disagrees with the decision, they go over the appeal rights information with them to assure they understand their rights.

Participants may initiate an appeal for:
•Refusal to accept a request for services;
•Finding of ineligibility;
•Failure to act on a request for services within the mandated time period;
•Denial of service; or
•Suspension, termination, or reduction of services.

89 Ill. Admin. Code 102 and 104 describe how to request a fair hearing and the procedures used during the appeal process. If a participant/applicant receives notice of an adverse action, they have 60 days to file an appeal.

The MA currently has hearing officers and administrative law judges (ALJ) that conduct hearings. A hearing officer/ALJ will conduct the hearing at the MA Chicago office or DHS local office closest to the family's home. The family, the hearing officer/ALJ and a MA representative will participate in the hearing. The hearing officer/ALJ may participate in person, by telephone or videoconference.

During the hearing, the MA hearing officer/ALJ will conduct the hearing in a fair and impartial manner. The hearing officer/ALJ will allow the participant to present their case through documentary and testimonial evidence. The MA representative will testify how they reached their decision and any supporting documents. The participant may question the MA representative. When the hearing is concluded, the MA hearing officer/ALJ drafts a written recommended decision and sends it to the MA Hearing Supervisor for final review and sign-off by the Medicaid Director. The MA notifies the participant and MA Representative in writing of the final decision. The final administrative decision by the MA may be appealed to the State Circuit Court pursuant to the Administrative Review Law.

The MA rule (89 Ill. Adm. Code 104.70) provides that an appeal decision shall be given within 60 days of the date it was filed unless additional time is required, which may include postponement or continuance of a hearing for good cause as provided in 89 Ill. Adm. Code 104.45. The appeal process follows federally mandated rules that require all appeals to be treated equally and ensure due process is given for each appellant.

Training for the Medicaid hearing officer/ALJ is conducted in several ways; by group training, one-on-one mentoring, and shadowing of experienced Medicaid hearing officer/ALJ. Training encompasses training memos, conferences on administrative hearings, observing administrative hearings, review of previously conducted hearings, and the Medicaid waiver administrative codes and citations. All current HFS Medicaid hearing officer/ALJ have experience in HFS programs—either Medical Programs or Child Support. Monitoring of the hearing process and final decisions occurs in several ways:

•The scheduling Medicaid Hearing Officer Supervisor creates a monthly report with the disposition of all cases to assure that

hearings are being scheduled and moving through the process.

•Decisions go through three levels of HFS review:
1) the Medicaid Hearing Officer drafts the case
2) the Medicaid Hearing Supervisor reviews 100% of the cases
3) the Medicaid Director makes the final decision on every case

Quality Controls consist of reviewing cases for consistency in the application of the Medicaid laws and the use of sound legal reasoning. Trends and patterns are also considered as part of the quality oversight process.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

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).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The types of critical events or incidents, in addition to allegations of physical or mental abuse, neglect or financial exploitation, which must be reported to the OA include any event or failure to provide adequate or appropriate care that resulted in harm or potential harm to the child. This would include medication or treatment errors resulting in medical treatment; significant injuries; treatment protocols not followed; caregiver found to be drug or alcohol impaired or sleeping while on duty; participant left with an untrained caregiver or unattended; the unauthorized use of restraint, seclusion or restrictive interventions; a domestic crisis; environmental concerns; and failure to maintain at minimum an emergency phone line or utilities to support life support equipment. The nursing agencies and home medical equipment providers are to report all incidents of harm or potential harm to the OA care coordinator. The OA care coordinators report to the OA Home Care Program Support Unit (HCPSU) when they have knowledge of an incident. The OA reports any life safety concerns to the MA immediately.
-
Children under age 18 years

Any event that is alleged to result from physical or mental abuse, neglect or financial exploitation as described below is reported to the Illinois Department of Children and Family Services (DCFS), as the child welfare agency.
-
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 18. The types of critical incidents that must be reported include any specific incident of abuse or neglect or exploitation 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.
-
Reports made to DCFS for the children in the waiver may involve situations that would not normally be considered abuse or neglect. For example, failure to provide an environment that supports the technology or ensures access to emergency care can be life threatening because of the unique medical and technology needs of the children.
-
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 MA and the OA), 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, and 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 DCFS 24-hour hotline (800-25-ABUSE). Reports must be confirmed in writing to the local investigation unit within 48 hours of the hotline call.
-
Participants ages 18 through 20

Adult Protective Services Act

The State has passed legislation to consolidate to a single entity the reporting and investigation of abuse, neglect, financial exploitation (ANE), or self-neglect of eligible adults. Pursuant to Public Act 098-0049, the Illinois Department on Aging (DoA) 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, and hence, remove statutory authority from the DHS Office of Inspector General (OIG) to respond to allegations related to adults with disabilities,ages of 18 through 59, who reside in domestic situations. The DoA will establish by rule mandatory standards for the investigations and mandatory procedures for linking eligible adults to appropriate services and supports.

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.

For each enrolled nursing agency and home medical equipment vendor, the OA enters into an agreement, Requirements for Nursing Agencies Participating with the Illinois Department of Healthcare and Family Services Home Care Program, in addition to the Medicaid provider agreement. This agreement clearly outlines abuse and neglect reporting requirements, incident reporting and other safeguards. If non-compliance of these additional standards are not met or other reports find a provider in non-compliance, new admissions will be held until compliance is met. If conditions found are a more immediate threat to a child or children, cases will be transferred to other providers. Life safety concerns are reported to the MA immediately. All findings and remediation are reported to the MA at least quarterly.

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.

-
Families are informed that the nurses and OA staff are mandated reporters when they establish the Negotiated Roles and Responsibilities with the family and nursing agency.
-
Families are also given a copy of the Guidelines for Parents with nurses in the home. This document contains information about abuse and neglect, that nurses are mandated reports, and includes advice such as not to share money with the nurses and how to maintain boundaries.
-
The numbers to the Abuse and Neglect hotlines for DCFS and Adult Protective Services are listed on the Emergency Home Information list.
-
The OA provides the three documents initially and reviews the documents annually with the families.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

-
The OA receives reports of critical events or incidents and monitors them to resolution. The types of intervention or reporting are related to the nature of the event. OA care coordinators report to the OA Home Care Program Support Unit (HCPSU) when they are aware of reports made or they initiate a report to the Department of Children and Family Services (DCFS) or the Department on Aging's Adult Protective Service (APS) hotline. The OA also reports incidents to the Illinois Department of Financial and Professional Regulations (IDFPR)when indicated. When the HCPSU is notified of reports made to DCFS, APS or IDFPR for an investigation, the OA closely monitors the

investigation.
-
The MA and OA do not play a direct role in the investigation of critical events that are reported through the State authorities that are responsible for conducting investigations. It is the OA's responsibility to report the incident and assure the health and safety of the waiver participant during the investigatory phase and after. If an incident is reported that does not rise to the level of the State investigatory authorities, the OA will work with the family or the provider to address and remediate the issue.
-
For each enrolled nursing agency and home medical equipment vendor, the OA enters into an agreement in addition to the Medicaid provider agreement. This agreement clearly outlines abuse and neglect reporting requirements, incident reporting and other safeguards. If non-compliance of these additional standards are not met or other reports find a provider in non-compliance, new admissions will be held until compliance is met. If conditions found are a more immediate threat to a child or children, cases will be transferred to other providers.

All findings and remediation are reported to the MA at least quarterly. Life safety concerns are reported to the MA immediately.

Investigations of abuse, neglect or exploitation are conducted by the authorized entities, according to their governing rules, described in Section G.1.b., as follows:

1) Illinois Department of Children and Family Services (DCFS) for persons under age 18
-
Abuse/Neglect investigations are initiated without delay if immediate danger or harm is reported. Investigations are initiated within 24 hours after the report is taken if it relates to inadequate shelter or environmental neglect. DCFS has up to 60 days to complete an investigation and make the final determination. A 30-day extension can be granted for good cause.
-
Participants aged 17 and younger and their families, as appropriate, are notified within five calendar days of the completed investigation. The alleged perpetrator and participant's caretaker are notified in writing of the DCFS final finding within 10 days after final determination is entered into State Central Registry.
-
If a finding is indicated, the perpetrator's name is placed on the DCFS State Central Register for a minimum of 5 years, 20 years for serious physical injury and 50 years for sexual penetration or death. If the investigation is unfounded, the alleged perpetrator's name remains on the DCFS Register for a minimum of 30 days up to 3 years depending on the seriousness of the situation.
-
2) Adult Protective Services Act

The State has passed legislation to consolidate to a single entity the reporting and investigation of abuse, neglect, financial exploitation (ANE), or self-neglect of eligible adults. The Illinois Department on Aging (DoA) 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, and hence, remove statutory authority from the DHS Office of Inspector General (OIG) to respond to allegations related to adults with disabilities, ages 18 through 59, who reside in domestic situations. 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.

The DoA will use the same model for responding to allegations of abuse of adults with disabilities, ages 18-59, as it currently uses for adults age 60 and over. 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 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.

-

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

-

The OA is responsible to track and follow all incidents to resolution, even those investigated by the DCFS or the Adult Protective Services unit. Incident reports are filed with the OA when the care coordinator becomes aware that a provider did not comply with OA requirements or when there has been harm or suspected harm to a child as described under Section G.1.b. Response or clarification is obtained from the provider as needed. Each situation is addressed based on what occurred.

The OA provides education for all new staff initally and ongoing as needed to make certain the waiver regulations, and the OA policies and procedures are followed. Nurses employed by approved nursing agencies providing services to children in the MFTD waiver are required to sign the Illinois DCFS CANTS 22 form, Acknowledgment of Mandated Reporter Status, and complete the DCFS On-line Training for Mandated Reporters. By signing the OA requirements and standards, providers agree to comply with laws governing the reporting of abuse or neglect.
-
Annually the nursing agencies and home medical equipment providers review and sign the OA Requirements that include a statement "report all incidents of harm or potential harm to the OA care coordinator".
-
The critical event reports are entered into a database for additional analysis. Each incident is closely monitored, and used in monitoring and identifying training and technical assistance needs.
-
OA staff responds to complaints, referrals or worrisome trends with more frequent reviews. For example, prior to sending the annual renewal packet, the OA reviews the database for patterns in the frequency of incident reports for the same nursing agency or HME provider. When a pattern is identified with a provider, the OA conducts an on-site review or contacts the agency administration.
-
A report is created quarterly that includes the calls made to DCFS, nurses that are reported to DFPR and other incident reports and is shared and reviewed with the MA at quarterly quality meetings. High risk incidents are shared with the MA and handled immediately.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical

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

-
Restraints are only allowed when ordered by a physician for safety and positioning. Seclusion is not allowed. Restraints are not allowed for the purpose of punishment or convenience of the caregiver.
-
Waiver services and supports are typically provided in the participant's home, but the waiver allows for services to be provided in community-based alternative health care settings and Medically Supervised Day Care as adjuncts to in-home care.
-
The waiver approves Children's Community-Based Health Care Centers (CCHCC) Model, licensed by the Illinois Department of Public Health (DPH) to provide nursing, respite and Medically Supervised Day Care. DPH rule 77 Illinois Administrative Code (ILAC) 260 is the license authority.
-
77 ILAC 260.1900 m) and n), governing restraint use in the setting, under Child's Rights states:
-
m) Neither physical restraints nor confinements shall be employed for the purpose of punishment or for the convenience of any facility personnel or volunteer. High chairs, playpens, cribs or youth beds are not restraints for children less than four years old.
-
Types of restraints permitted:

n) Restraints shall be used only for the safety and security of the child upon written order of the attending physician and with the informed consent of the child's representative. The physician's written authorization shall specify the precise time periods and conditions in which any restraints or confinements shall be employed. The reasons for ordering and using restraints shall be recorded in the child's plan.
-
Alternatives to restraints: As stated above, only the restraints ordered by a physician for safety and positioning are utilized.
-
Additional safeguards have been added to the annual provider agreement between the OA and the CCHCC. The OA requires that the CCHCC submit to the OA care coordinator written documentation and follow-up of any incident that poses a threat to the child's health or welfare, which includes the use of restraints. The incidents must be reported at the time of occurrence.
-
Training and Education: All staff must be trained on the type of restraint ordered by the physician. A child-specific checklist is used to orient staff on specific needs of the child including restraints, if applicable.

In 2012, the OA amended the Requirements for Nursing Agencies Participating with the Illinois Department of Healthcare and Family Services Home Care Program agreement to include a policy on restraints and restrictive intervention. The OA reviews provider policies regarding restraints and restrictive interventions at least annually. Critical incidents involving restraints/restrictive interventions are followed to resolution. If the restraints/restrictive interventions arose to the level of abuse or neglect, it would be reported to the appropriate State investigatory authority and the OA would assure the health and safety of the waiver participant.

The Requirements for Nursing Agencies Participating with the Illinois Department of Healthcare and Family Services Home Care Program agreement also requires the nursing agencies to submit to the OA's Care Coordinator written documentation of any incident that poses a threat to the child's health or welfare, including but not limited to injuries, medication errors, or use of restraints within 5 business days. If during the annual nursing agency quality review or through other documentation, incidents including the inappropriate/ineffective use of restraints and seclusion are discovered, further review will be conducted, remediation will occur and be followed through to resolution.

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:

-
Improper or inappropriate use of a restraint in the in-home setting is a reportable incident to the OA. Remediation or action taken is dependent on the circumstance.
-
In the Requirements for Nursing Agencies Participating with the Illinois Department of Healthcare and Family Services Home Care Program agreement the nursing agencies are instructed to submit to the OA's Care Coordinator written documentation of any incident that poses a threat to the child's health or welfare, including but not limited to injuries, medication errors, or use of restraints within 5 business days. If during the annual nursing agency quality review or through other documentation, incidents including the inappropriate//ineffective use of restraints and seclusion are discovered, further review will be conducted, remediation will occur and be followed through to resolution.

The OA amended the nursing agency provider requirements in 2012 to include a policy on restraints and restrictive intervention. OA reviews provider policies regarding restraints and restrictive interventions at least annually. If the restraints/restrictive interventions arose to the level of abuse or neglect, it would be reported to the appropriate State investigatory authority and the OA would assure the health and safety of the waiver participant.

In addition to requiring in the annual provider agreement, the OA requires the Children's Community-Based Health Care Centers (CCHCCs) to report restraint use as an incident. The OA annually renews the agreement with the CCHCCs and reviews the status of license or certification of staff, including sanctions. The OA conducts a full onsite review of the CCHCC initially and annually to review compliance with the agreement.

The Illinois Department of Public Health (DPH) conducts annual license and complaint investigation reviews of the CCHCCs. The protocol for annual license surveys includes a review of incidents and use of restraints during the previous year.
-
The OA shares immediate concerns with the MA at the time of the discovery. Summaries of monitoring reviews and findings are shared with the MA in a quarterly report. The quarterly reports are discussed at quarterly meetings.

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:

Methods to detect unauthorized use of restrictive interventions:
-
The OA care coordinator is responsible for monitoring participant health and welfare. The OA care coordinator contacts the family regularly regarding the service satisfaction and any concerns regarding nursing care. Nursing agency supervisors visit the participant's home every 60 days and send a summary report, including any changes or concerns, to the OA care coordinators for review. Unauthorized use of restrictive interventions that result in harm or potential mental or physical harm to the participant is a reportable incident to the OA. Remediation or action taken by the OA is dependent on the circumstance.
-
The Department of Public Health (DPH) is the State agency that licenses the Children's Community-Based Health Care Centers (CCHCC). DPH is responsible for follow-up and oversight. DPH conducts annual visits for license renewal and complaint investigations. The reviews include review of incident reports and verification that unauthorized use of restrictive interventions is not utilized.
-

In addition, the OA verifies annually that the nurses employed by the approved nursing agencies, CCHCCs and Medically Supervised Day Cares have a current Illinois license. The OA conducts an onsite review at the approved nursing agencies, CCHCCs and Medically Supervised Day Cares (if actively providing waiver services) annually to verify compliance with the agreement. Nursing agency onsite reviews include family interviews of service satisfaction or care concerns.
-

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services**
Complete Items G-2-b-i and G-2-b-ii.

i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. **Use of Seclusion.** *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The State does not permit seclusion.

Methods to detect seclusion:

The OA care coordinator is responsible for monitoring participant health and welfare. The OA care coordinator contacts the family, at least monthly, regarding the service satisfaction and any concerns regarding nursing care. Nursing agency supervisors visit the participant's home every 60 days and send a summary report, including any changes or concerns, to the OA care coordinators for review. Use of seclusion is a reportable incident to the OA. Remediation or action taken by the OA is dependent on the circumstance and if determined to be necessary, a report will be filed with the Department of Children and Family Services, if it pertains to an individual under the age of 18 or to Adult Protective Services for individuals over the age of 18 for an investigation of abuse.

The Department of Public Health (DPH) is the State agency that licenses the Children's Community-Based Health Care Centers (CCHCC). DPH is responsible for follow-up and oversight. DPH conducts annual visits for license renewal and complaint investigations. The reviews include review of incident reports and verification that seclusion does not occur.

In addition, the OA verifies annually that the nurses employed by the approved nursing agencies, CCHCCs and Medically Supervised Day Cares have a current Illinois license. The OA conducts an onsite review at the

approved nursing agencies, CCHCCs and Medically Supervised Day Cares (if actively providing waiver services) annually to verify compliance with the agreement and to review agency policy of use of restraint and seclusion. Nursing agency onsite reviews also include family interviews of service satisfaction or care concerns.

○ **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.

The waiver approves Children's Community-Based Health Care Centers (CCHCC) Model, licensed by the Illinois Department of Public Health (DPH), to provide Respite services continuously for up to 14 days, for participants in the waiver. The CCHCC would be the entity responsible for monitoring participant medications regiments while receiving respite services during round the clock stays. Medications are typically brought from home for the short respite stay in the Center.

DPH rule 77 Illinois Administrative Code (ILAC) 260 is the license authority.

Section 77 ILAC 260.2100 Medication Administration requires:

a)Except for medications allowed in subsection (b) of this Section, the only medications allowed in the facility are those for particular individual children. The medication of each child shall be kept and stored in the original container received from the pharmacy.

1)Each multidose medication container shall indicate the child's name, physician's name, prescription number, name, strength and quantity of drug, date this container was last filled, the initials of the pharmacist filling the prescription, the identity of the pharmacy, the refill date and any necessary special instructions.

2)Each single unit or unit dose package shall contain the proprietary and nonproprietary name of the drug and the strength of the dose. The name of the child and the physician do not have to be on the label of the

package, but they must be identified with the package in such a manner as to assure that the drug is administered to the correct resident.

b)A facility may stock a small supply of medications regularly available without prescription at a commercial pharmacy, such as: noncontrolled cough syrups, laxatives, and analgesics. These shall be given to a child only upon the order of a physician.

c)The facility shall have a first aid kit that contains items appropriate to treat minor cuts, burns, abrasions, etc.

d)All medications shall be properly stored in a secured location not accessible to unauthorized individuals.

e)All medications shall be sent home with the child for whom the medication was prescribed.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The Children's Community-Based Health Care Centers (CCHCC) are licensed by DPH. DPH is responsible for follow-up and oversight. DPH conducts annual visits for license renewal, which includes verification of compliance with the requirements for medication administration through review of the medical records, including incident reports. DPH also conducts complaint investigations.

In addition, the OA verifies annually that the nurses employed by the CCHCC have a current Illinois license and conducts an onsite review at the CCHCC annually.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. **Provider Administration of Medications.** *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Medications are administered or self-administration of medications is supervised by licensed nurses employed by the waiver provider, according to the Nursing and Advanced Practice Nursing Act 225 Illinois Compiled Statutes 65.

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:

The Illinois Department of Public Health (DPH), as the licensing agency, is responsible for follow-up and

oversight of medications error reporting in the Children's Community-Based Health Care Centers (CCHCC).

The OA receives incident reports, which include medication errors, from the provider.

(b) Specify the types of medication errors that providers are required to *record:*

DPH, as the licensing agency, requires that incident reports be completed when medications are omitted or the wrong dose is given.

The OA requires that the Children's Community-Based Health Care Center record medication errors.

(c) Specify the types of medication errors that providers must *report* to the State:

DPH is notified if the participant has to seek treatment or is hospitalized as a result of the medication error.

The OA care coordinator is notified through the incident report if a medication error results in hospitalization or medical treatment. Any incidents, such as medication errors, which pose a threat to the child's health or welfare, are reportable.

○ **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.

DPH, as the licensing agency, is responsible for follow-up and oversight of medications error reporting in the Children's Community-Based Health Care Centers (CCHCC). Medication errors are reported as incidents within the CCHCC. DPH conducts complaint investigations and annual visits for license renewal, which includes a review of incidents involving medication errors.

The OA verifies annually that the nurses employed by the CCHCC have a current Illinois license and conducts an onsite review at the CCHCC annually. The OA maintains a database of incidents to track trends and patterns. The OA reviews the incident database prior to annual onsite review at the CCHCC. Also, incident and quality review results are included in the quarterly reports submitted to the MA.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*
   i. **Sub-Assurances:**
      a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
30G: # and % of critical incidents, including those involving alleged abuse or neglect, that were reported within 5 business days. N: # of critical incidents that were reported within 5 business days. D: # of critical incidents that were reported.

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

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	**Frequency of data aggregation and**

aggregation and analysis *(check each that applies):*	**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:
31G: # and % of participants' deaths where action was taken when the need for further investigation was identified. N: # of participant's deaths where action was taken when further intervention was identified. D: Total # of participant's deaths where further intervention was identified.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
32G: # and % of critical incidents reported to the investigatory agency, including those involving alleged abuse or neglect, that were monitored to resolution, as specified in the approved waiver. N: # of critical incidents reported to the investigatory agency, including those involving alleged abuse or neglect, that were monitored to resolution. D: # of critical incidents reported.

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
33G: # and % of participants with inappropriate manual or physical restraint or seclusion incidents that were reported within 5 business days. N: # of participants with inappropriate manual or physical restraint or seclusion incidents that were reported within 5 business days. D: Total # of participants with inappropriate manual or physical restraints or seclusions.

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

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:
34G: # and % of participants with critical incidents involving inappropriate manual or physical restraints or seclusion occurred. N: # of inappropriate manual or physical restraints or seclusion when follow-up adhered to state policies and procedures. D: # of critical incidents reported.

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

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

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
35G: # and % of participants with medication or treatment errors resulting in the waiver participant requiring medical treatment that were reported within 5 business days. N: # of participants w/ med. or treat. errors resulting in the part.

requiring med. treat. that were reported within 5 bus. days. D: Total # of participants w/ med. or treat. errors resulting in the part. requiring med. treat.

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

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:
36G: # and % of participants reviewed who received and required coordination and support to access healthcare services identified in the Assessment of Need (AON). N: # of participants reviewed who received and required support to access healthcare services. D: # of participants in the representative sample with healthcare needs identified in their AON and required to access healthcare services.

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

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

Data Aggregation and Analysis:

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

that applies):	
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
30G: OA requires the nursing agency to submit a corrective action plan for addressing timeliness of reporting incidents. If compliance with reporting continues to be an issue, the OA will provide additional training or technical assistance to the nursing agency or adverse actions will be applied.

31G: OA follows-up with the nursing agency and tracks until each incident is fully resolved. If reportable incidents continue to be an issue, OA will provide additional training or technical assistance to the nursing agency or adverse actions will be applied. System improvements are also implemented if issues appear to be systemic.

32G: OA requires the nursing agency to submit a corrective action plan to take action when the need for further intervention has been identified and how these incidents of non-compliance will be prevented in the future. OA follows-up with the nursing agency and tracks until fully compliant. If lack of action continues to be an issue, OA will provide additional training or technical assistance to the nursing agency or adverse actions will be applied. System improvements are also implemented if issues appear to be systemic.

33G: OA requires provider to submit a corrective action plan to address untimely reporting. OA follows-up with the provider and tracks until fully compliant. If errors and timeliness of reporting continue to be an issue, OA will provide additional training or technical assistance to the provider or adverse actions will be applied. System improvements are also implemented if issues appear to be systemic.

34G: OA requires the provider to submit a corrective action plan for inappropriate restraint or seclusion incidents and how these incidents will be submitted timely and prevented in the future. OA follows-up with the provider and tracks until fully compliant. If restraint or seclusion incidents and untimely reporting continue to be an issue, OA will provide additional training or technical assistance to the nursing agency or adverse actions will be applied. System improvements are also implemented if issues appear to be systemic.

35G: OA requires the nursing agency to submit a corrective action plan for addressing timeliness of reporting medication or treatment errors. If compliance with reporting continues to be an issue, the OA will provide additional training or technical assistance to the nursing agency or adverse actions will be applied.

36G: The OA requires that the OA regional office submit a corrective action plan to address how the care coordinator will provide support to access healthcare services when needs are identified. The OA follows-up with the OA regional office and tracks until fully compliant. If not compliant, the OA will provide additional training or technical assistance.

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 Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

-
The Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency (MA), and the University of Illinois-Chicago, Division of Specialized Care for Children, as the Operating Agency (OA), 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 assurances.
-
The OA is responsible for the majority of the data collection to address the Quality Management System discovery and remediation sections located in the Appendices. The State's system improvement activities are in response to aggregated and analyzed discovery and remediation data collected on each of the assurances.

-
The sources of discovery evidence vary, but all are based on either a 100 % or the representative sampling methodology as indicated for each performance measure. The OA conducts onsite reviews annually for OA Regional Offices, Nursing Agencies, and Children's Community-Based Health Care Centers. The OA conducts desk reviews annually for the Home Medical Equipment Providers. Data is collected throughout the year and individual problems are remediated as they are identified. Other data sources include the OA database, the MA database, the MMIS, Medical Data Warehouse and other quality assurance reviews, record reviews and reports as indicated in the waiver. In addition, the OA maintains a critical incident database. This is reviewed quarterly and based on patterns and trends identified, policy and system changes have been made.
-
In addition to the program monitoring conducted by the OA, the MA conducts an annual desk audit from a statewide random selection of participants. The desk audit includes a review of level of care determination, plan of care, services provided from outside entities, and claims for home medical equipment and supplies. The MA also conducts a comprehensive interview with the family caregivers regarding services and supports from DSCC, nursing agencies, and HME providers. The MA reports the findings to the OA for follow-up and remediation.
-
The OA participates with the MA in the Quality Management Committee (QMC) meeting each quarter to review data collected from the previous quarter and for the year to date. Data to be collected semi-annually or annually are reported as indicated by the performance measure in the waiver. All reports are provided to the MA for review prior to the quarterly meetings. Annual reports are produced identifying trends based on the full representative sample and/or 100% review of data.
-
Data is reported by individual performance measure. Individual performance measure reports include timeliness of remediation based on timelines identified in the waiver and includes progress on remediation.
-
The MA and OA identify trends based on scope, severity, changes and patterns of compliance. Identified trends are discussed and analyzed regarding cause, contributing factors and opportunities for system improvement. Suggestions for system changes are added to the OA's Waiver QMC System Improvement Log for tracking purposes. Decisions and timelines regarding system improvement are made based on consensus of priority and specific steps needed to accomplish change.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

Processes are outlined under each performance measure. The MA and OA work together to monitor and analyze performance measures on an ongoing basis. At least quarterly, key staff of the MA and the OA review 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, record reviews, surveys

from other agencies, and service provider reviews. Multiple years of data collection will alow the State to evaluate the effectiveness of system improvements over time.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Each year, one quarterly meeting is devoted to an overview of the previous year's activities and discussion of whether changes are needed to the overall Quality Improvement Strategy. At the meeting, the MA and OA discuss whether to make changes in existing performance measures, add measures or discontinue measures. The State continually strives to increase the compliance rate of each performance. 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 full (100%) compliance.

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).

The OA conducts an ongoing Random Moment Sampling (RMS) to document time and work activities of regional office care coordination staff. The time study data combined with the administrative/operational costs are summarized in a Program Cost Study prepared each fiscal quarter for both the Home and Community Based Waiver and the Core Program's Administrative Case Management costs for children in Medicaid. The collection of the time and financial data allows the OA to document and allocate staff time and costs to the agency's programs and work activities.

The program Cost Study is compiled under a contract with MAXIMUS Inc. The OA main office reconciles costs incurred by by UIC-DSCC; therefore costs have been verified before being recorded in the MAXIMUS report. This report is used to support the OA's administrative claim for both respective programs to the MA.

The OA submits to the MA-Bureau of Program and Reimbursement Analysis (BPRA) a quarterly certification statement, which certifies the Core Program Administrative Costs and the Home and Community Based Waiver costs, a Program Cost Study, and a C-13. This documentation is reviewed for accuracy. After the C-13 has been processed and paid the waiver and core program case management expenses can be claimed on the CMS 64.

Once a year a quarter is chosen for a detailed review of the Program Cost Study by BPRA. The OA submits expenditure reports to the Medicaid Agency for review. These expenditure reports are reconciled to the Program Cost Study and costs are examined for applicability and allowability.

The MA monitors the financial aspects of the waiver from a global perspective, using its data warehouse query capability to determine if waiver clients are less than 21, if clients are in a nursing facility and also receiving waiver services or determine if waiver services are being claimed after the client has passed.

Since most of the waiver services are paid via C-13, a sample of C-13s are selected each year for review. The applicable documentation supporting the C-13's is reviewed to ensure that the services meet all waiver criteria.

The Single Audit Act of 1984 (Act) and the Single Audit Act Amendments of 1996 applies to this Waiver. The 30 ILCS 5/3 specifies the jurisdiction of the Auditor General and section 3-2 identifies the mandatory post audits. In conjunction with HFS' portion of the Statewide Single Audit, a sample of provider billings for Medicaid payments, that may include billings for Medicaid payments for waiver services, are reviewed. The Illinois Office of the Auditor General is responsible for conducting the financial audit program.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

State's methods for discovery and remediation.

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
37I: # and % of waiver claims that were paid using the correct rate as specified in the waiver application. N: # of waiver claims that were paid using the correct rate as specified in the waiver application. D: Total # of waiver claims paid.

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

	Ongoing	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:
38I: # and % of waiver service claims that were paid for participants who were enrolled in the waiver on the date the service was delivered. N: # of waiver service claims that were paid for participants who were enrolled in the waiver on the date the service was delivered. D: Total # of waiver service claims paid.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MA 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:
39I: # and % of paid waiver service claims that are specified in the participant's service plan. N: # of paid waiver service claims that are specified in the participant's service plan. D: Total # of paid waiver service claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MA Data Warehouse and OA Service Plan Authorizations

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 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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

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

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
37I: MA will require that OA recoup any overpayment or repay at correct rate. MA will adjust the federal claim and require OA to check edits and fix any issues found.

38I: MA will adjust the federal claim for services provided prior to enrollment and check MMIS system edits and fix any issues found.

39I: If authorized, MA will revise waiver participant's service plan. If not authorized, MA will back out of the federal claim that is not specified in the participant's service plan.

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: Semi-Annually

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

◉ **No**
○ **Yes**
Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rate determination methods for each service are outlined below:
-
Respite (in-home):
The MA establishes rates for in home respite for Registered Nurse (RN), Licensed Practical Nurse (LPN) and Certified Nurse Aide (CNA). Respite rates are based on the MA rates for in-home Shift Nursing agency rates. These rates are based on the PDN rates in the State Plan that indicates that "In-home shift nursing payments for children who are under 21, shall be at the MAs established hourly rate to an agency licensed to provide these services". Reimbursement of in-home shift nursing care is codified in the MA's administrative rules at 89 Ill. Adm. Code 140.474(c). For children under 21, there is a geographic differential for these rates. These rates do not include room and board.
-
Exceptions to the rates can be made if certain conditions exist that may include complexity of care and difficulty in staffing. Prior approval for a rate exception is required and made by the MA. Home Health rates are available to the public through the MA's website on the Home Health fee schedule. The fee schedules will be added to the following link: http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/tdmfc.aspx
-
Respite (out-of-home):
The MA establishes rates for center based services. The rate is an hourly rate and is based on averaging utilization of licensed and non-licensed nursing rates that are established through the State Plan for in-home shift nursing. This rate is not geographically-based and room and board and transportation are excluded from the rate. The rates are contained on the MAs website at the link above.

Nurse Training:
The MA establishes an hourly rate based on the hourly in-home shift nursing rate for an RN or and LPN, established through the State Plan. See in-home shift nursing rate description under in-home respite service above. This service is prior approved by the MA. The rates are contained on the MAs website at the link above.

Family Training:
Family Training is prior approved by the MA and may be provided by a nurse or by a community based entity. The family training nursing rates are based on the hourly in-home shift nursing rate description under the in-home respite service described above. Family training may also include other types of training, such as CPR. If other types of training are provided the rates may vary. The MA would pay the public rate for the service. The service is prior approved by the MA. The rates are contained on the MAs website at the link above.

Specialized Medical Equipment and Supplies:
Specialized medical equipment and supplies are based on the usual and customary charge for these services. If the cost of those services exceeds $2,000, bids from three qualified providers, when available, are required and the lowest bid that meets the child's needs is selected. The MA has established a cap of $25,000 over a five-year period for a combination of specialized medical equipment and supplies and environmental modifications. The rates are contained on the MAs website at the link above.

Environmental Modifications:
Environmental modifications are paid at the vendor's charges. All environmental modifications are reviewed by the MA to determine medical necessity prior to the item being supplied. If the request is for an item costing less than $2,000, only one bid is required. If the cost of the work is more than $2,000, three bids must be submitted to the MA for review. The least costly bid that meets the child's medical needs is approved. The MA has established a cap of $25,000 over a five-year period for a combination of specialized medical equipment and supplies and environmental modifications. The rates are contained on the MAs website at the link above.

Medically Supervised Day Care:
There are currently no licensed providers. The current rate is based on a case-mix of licensed and unlicensed staff. The reimbursement of medically supervised day care is codified in the MA's rules at 89 Ill. Adm. Code Section

145.550(d). It is not geographically-based and does not include room and board. The rates are contained on the MAs website at the link above.

Placement Maintenance Counseling:
MA establishes the rate. It was based on the rate for similar mental health counseling services, under the State Plan. The service is prior approved by the MA. It is not geographically-based and does not include room and board. The rates are contained on the MAs website at the link above.
-
General Information:
The MA solicits public comments by means of a public notice when changes in methods and standards for establishing payment rates under the Waiver are proposed. The notice is published in accordance with federal requirements at 42 CFR 447.205, which prescribes the content and publication criteria for the notice. The OA uses the HFS 2352 to share rate information with waiver participants and families. Copies of rate methodologies are on file with the MA.

Families receive a copy of the HFS 2352 that includes the approved service and rate of payment.

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:

-
Respite (in-home):

In-home respite is billed and paid through the OA, using an HFS appropriation. The interagency agreement between the OA and HFS specifically identifies the program and fiscal responsibilities of both agencies in their efforts to administer the waiver program. As part of the agreement, the OA is assigned the responsibility to maintain a provider data base of HFS approved nursing and respite providers and to receive and adjudicate claims for respite services as they relate to an eligible participant and their home care treatment plan.

The OA claims processors review the claims received from approved providers and reconcile the services charged with the participant's approved treatment plan. Once the charges are approved for payment, a voucher file is created for payment by the State. The OA then creates an electronic payment file to send to the State Comptroller. The nursing agencies are paid on an expedited schedule from a HFS State appropriation. The OA sends a separate electronic claims file to HFS to record each claim transaction into HFS'Medicaid Management Information System. The OA and HFS fiscal staff complete a claims and appropriation reconciliation on a regular basis to assure the payments made to the nursing providers agree to the payments posted into the HFS claims system. The provider voluntarily completes a provider agreement that reassigns payment from HFS to the OA.

Respite (out-of-home):
Respite care provided by a facility established as a Children's Community-Based Health Care Center pursuant to the Alternative Health Care Delivery Act [210ILCS 3/35], is billed directly to the OA. The flow of billings is described above. The only difference is that payments are made to the Children's Community-Based Health Care Center.

Nurse Training: The OA care coordinators submit requests for nurse training to the MA for prior approval. Once approved, the OA creates an electronic payment file to send to the State Comptroller for payment using the MA appropriation. After payment is made, an electronic file is submitted to the MA MMIS for processing federal match.

Family Training:
The OA care coordinators submit requests for family training to the MA for prior approval by the MA. These services are billed directly to the MA, and paid through a manual (C-13) voucher process.

Special Medical Equipment and Supplies:
The OA care coordinators obtain all required bids from potential vendors and submit the bids along with supporting medical information to the MA for approval prior to the service being rendered. If approved, the MA sends written notification to the OA care coordinator that the service has been authorized and, if more than one bid was submitted, the selected vendor. The OA care coordinator contacts the family and/or provider. These services are billed directly to MA, and paid through a manual (C-13) voucher process.

Environmental Modifications:
The OA care coordinators obtain all required bids from potential vendors and submit the bids along with supporting medical information to the MA for approval prior to the service being rendered. If approved, the MA sends written notification to the OA care coordinator that the work has been authorized and, if more than one bid was submitted, the selected vendor. The OA care coordinator contacts the family and/or vendor. The claim is received by the OA care coordinator who verifies completion of the work. If approved, the voucher is forwarded to the MA for payment using a manual (C-13) voucher process.

Medically Supervised Day Care:
Medically supervised day care is provided by a facility established as a Children's Community-Based Health Care Center pursuant to the Alternative Health Care Delivery Act [210ILCS 3/35]. Medically supervised day care is billed and paid through the OA, through a MA appropriation. The interagency agreement between the OA and MA specifically identifies the program and fiscal responsibilities of both agencies in their efforts to administer the waiver program. Once the charges are approved for payment, a voucher file is created for payment by the State. The OA then creates an electronic payment file to send to the State Comptroller for payment to the Children's Community-Based Health Care Center.

Placement Maintenance Counseling:
The OA care coordinators submit requests for maintenance counseling to the MA for prior approval. These services are billed directly to the MA, and paid through a manual (C-13) voucher process.

If a provider chooses not to assign payment to the OA, the provider will sign the standard Medicaid provider agreement (HFS 1413).
-

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:

-
Both the OA and MA validate provider billings. Below is a description of the billing validation process for each service.

Respite (in-home and out-of-home), Nurse Training and Medically Supervised Day Care:

After the OA approves the respite or nurse training charges for payment, a voucher file is created and the providers are paid. The OA claims processing unit verifies the hours of nursing and respite that are approved when processing the claims.

The OA then sends a separate electronic claims file to the MA to record each claim transaction into the Medicaid Management Information System (MMIS). The MMIS applies processing edits to verify Medicaid eligibility for the child, reject duplicate claims, adjust claims with third party liability etc. Any rejections are sent back to the OA via a remittance advice for review and reconciliation. Post-payment reviews of provider records are performed by the OA and post-payment audits performed by MA.

Services paid outside of the MMIS by the MA via C13 Process through the Public Aid Accounting System:

All other services are paid by the MA through the Public Aid Accounting System. Client and provider eligibility for the date of service are checked each time a payment for a waiver service is processed. A printout of the eligibility screen is included as part of the backup documentation for each payment voucher. As part of case management responsibilities, the OA care coordinators verify that the service is included in the approved service plan. The care coordinator regularly contacts family and discusses services provided since the last contact. This would include discussion that family training and placement maintenance counseling was conducted.

Verification of home modifications and special equipment is performed by the OA through home visits. Home visits are made as often as needed and may be done for this purpose. Phone contact with the parent may verify the work was done. Nursing agencies also indicate changes to the home environment in the 60 day supervisory summary report.
-

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:

The following waiver services are paid through the Public Aid Accounting System [PAAS] through a manual C-13 process: Placement Maintenance Counseling; Environmental Modifications; Family Training; and Specialized Equipment and Supplies.

The OA care coordinator submits requests for payment of these waiver services to the MA, Bureau of Comprehensive Health Services (BCHS). All requests for environmental modifications and specialized medical equipment and supplies are reviewed for medical necessity. Three bids are required for environmental modifications or equipment/supplies costing $2,000 or more. Environmental modifications or equipment/supplies costing less than $2,000 require one bid.

Once an approved service is rendered, the OA care coordinator submits the bill to BCHS for processing. These services are processed on a C-13 Payment Voucher through PAAS. The C-13 vouchers are prepared by BCHS and sent to the Bureau of Administrative Support Services (BMAS) for data entry into PAAS.

The draw of federal funds and claiming of these waiver services on the CMS-64 is based on the following Category of Service [COS] and Activity Code used in PAAS:

Waiver Service Category of Service Activity Code
Counseling: CS M16P
Utility Assistance: EA M15F
Environmental Modifications: EM M15D
Extermination Services: ES M15D
Family Training FT M16F
Specialized Equip/Supplies: ME M15H

As stated previously, the OA pays nursing agencies and the Children's Community-Based Health Care Center directly for nursing services and medically supervised day care; and pays nursing agencies for nurse training.

The OA pays the bills directly, using a MA appropriation. The OA maintains a provider database of the MA approved nursing, respite, nurse training, and medically supervised day care providers. The OA's claims processors review the bills received from approved providers and reconcile the services charged with the child's approved treatment plan. Once the charges are approved for payment, a voucher file is created for payment by the State. The OA creates an electronic payment file to send to the State Comptroller. The nursing agencies and Community-Based Children's Health Care Center are paid on an expedited schedule from a MA State appropriation. The OA sends a separate electronic claims file to the MA to record each claim transaction into Medicaid Management Information System. The OA and MA fiscal staff complete a claims and appropriation reconciliation on a regular basis to assure the payments made to the providers agree with the payments posted into the the MA's claims system. The provider voluntarily completes a provider agreement that reassigns payment from the MA to the OA. The draw of federal funds is on the CMS-64, and is based on approved HCPC codes, eligible providers, and medical eligibility of the child for the date of service.

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [ ] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [x] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

-
The OA serves as a limited fiscal agent for paying respite, nurse training and medically supervised day care claims. Functions are described in above sections: a) Flow of Billings and d) Billing Validation Process.

All nursing agencies are given the opportunity to bill the MA directly or sign an alternative provider agreement (HFS 1413A) that allows them to voluntarily choose billing through the OA.

MA oversight follows:
Once a year a quarter is chosen for a detailed review of the Program Cost Study. The OA submits expenditure reports to the MA for review. These expenditure reports are reconciled to the Program Cost Study and costs are examined for ensure they applicable and allowable.

During the waiver renewal period, the MA monitors the financial aspects of the waiver from a global perspective. The MA uses its medical data warehouse query capability to determine if waiver clients are less than 21, if clients are in a nursing facility and also receiving waiver services or determine if waiver services are being claimed after the death of a client.

Since most of the waiver services are paid via C-13, a sample of C-13s will be selected each year for review. The applicable documentation supporting the C-13s will be reviewed to ensure that the services meet all waiver criteria.
-

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

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

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ( ) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- (●) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

To the OA for respite, nurse training and medically supervised day care services.

ii. Organized Health Care Delivery System. *Select one:*

- (●) **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ( ) **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- [ ] **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
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: Hospital, 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	611.00	146077.09	146688.09	180849.02	7422.15	188271.17	41583.08
2	679.00	155391.10	156070.10	195825.50	21442.54	217268.04	61197.94
3	605.26	157946.80	158552.06	203505.50	22283.49	225788.99	67236.93
4	675.00	160544.50	161219.50	211495.60	23158.39	234653.99	73434.49
5	31991.97	163185.00	195176.97	219807.50	24068.53	243876.03	48699.06

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: Hospital	Level of Care: Nursing Facility
Year 1	700	666	34
Year 2	700	666	34
Year 3	825	785	40
Year 4	875	832	43
Year 5	1015	970	45

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.

For the renewal waiver that covers Waiver Fiscal Year (WFY) 2013 through 2017 (i.e. 09/01/2012 thru 08/31/17), the projected average length of stay was calculated by taking the total number of days that MFTD waiver recipients received a service during the previous waiver period (WFY 2007-WFY 2010) and dividing by the number of MFTD

waiver recipients receiving a waiver service. The changes in Length of Stay (LOS) data for WFY 2007 to WFY2010 were used to project changes in WFY2011 and WFY 2012 by the difference established by the average increase in Average Length of Stay (ALOS) over the past waiver years. This in turn established the base to which the same average increase was applied for the future years WFY 2013 - WFY 2017.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Factor D data was projected using the average change in service utilization for MFTD waiver recipients during the previous waiver renewal period-WFY 2007 through WFY 2011. Each waiver service was projected using utilization growth rates from WFY 2007 - WFY 2011 data. In cases where a trend could not be identified or in cases where the growth rate was deemed anomalous, the growth rate was assumed to be the same as the last complete year that we have data for. Factor D services are expected to grow at an average rate of 2.2% during the renewal.(Note: Due to the waiver extensions, year 5 projections from the currently approved waiver were carried over to year 1 of the proposed waiver.)

The data from the 372 was not used in the comparison due to the time frame involved. The Illinois Department of Healthcare and Family Services medical data warehouse is not a static system; new claims and adjustments are continually applied. The same numbers cannot be recreated when the time frame between the report and the waiver application are a period of several months. Therefore, the waiver application was completed with the most current information available.

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:

Ancillary service data was pulled for those MFTD waiver recipients in the previous renewal period that had a waiver procedure during WFY 2007 through WFY 2011. Factor D Prime is estimated to increase by 1.65% for WFY 2013 through WFY 2016. This percentage is based upon the average historical percent change for WFY 2007 through WFY 2011 actual ancillary expenditures per capita for MFTD waiver recipients and carried forward to WFY 2013 through WFY 2016. Ancillary cost data were adjusted to exclude prescription medicines now covered by Medicare Part D. This was accomplished by comparing the MFTD waiver population to the Medicare population to exclude those that were dual-eligible and again against the Medicare Part D excluded drug file to exclude services covered under Medicare Part D.(Note: Due to the waiver extensions, year 5 projections from the currently approved waiver were carried over to year 1 of the proposed waiver.)

The data from the 372 was not used in the comparison due to the time frame involved. The Illinois Department of Healthcare and Family Services medical data warehouse is not a static system; new claims and adjustments are continually applied. The same numbers cannot be recreated when the time frame between the report and the waiver application are a period of several months. Therefore, the waiver application was completed with the most current information available.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is the institutional cost per person for those under 21 years of age, with Inpatient Hospital lengths of stay of 45 days or longer, or clients under the age of 60 residing in a nursing home with a condition requiring a ventilator or tracheostomy, based on 6 or more MDS reports. Factor G is estimated to increase by 3.9% each year for WFY 2012 through WFY 2016 due to case mix and rate increases. This trending is based on the change in spending from WFY 2010 through WFY 2011. (Note: Due to the waiver extensions, year 5 projections from the currently approved waiver were carried over to year 1 of the proposed waiver.)

The 372 data was not used in comparison due to the time frame involved. The Illinois Department of Healthcare and Family Services medical data warehouse is not a static system; new claims and adjustments are continually applied. The same numbers cannot be recreated when the time frame between the report and the waiver application are a period of several months. Therefore, the waiver application was completed with the most current information available.

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:

For WFYs 2010 through 2012, Factor G Prime includes ancillary expenditures per capita for individuals residing in an institution and carried forward to WFY 2012. Factor G Prime is estimated to increase by 3.9% each year for WFY 2012 through WFY 2016. This trending is based on the change in spending from WFY 2010 through WFY 2011. These estimates include case mix and rate increases. (Note: Due to the waiver extensions, year 5 projections from the currently approved waiver were carried over to year 1 of the proposed waiver.)

Ancillary cost data were adjusted to exclude prescription medicines now covered by Medicare Part D. This was accomplished by comparing the MFTD waiver population to the Medicare population to exclude those that were dual-eligible and again against the Medicare Part D excluded drug file to exclude services that are covered under Medicare Part D. The data from the 372 was not used in the comparison due to the time frame involved. The Illinois Department of Healthcare and Family Services medical data warehouse is not a static system; new claims and adjustments are continually applied. The same numbers cannot be recreated when the time frame between the report and the waiver application are a period of several months. Therefore, the waiver application and amendment were completed with the most current information available.

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
Respite
Specialized Medical Equipment and Supplies
Certified Nursing Assistant (CNA)
Environmental Accessibility Adaptations
Family Training
In Home Shift Nursing
Medically Supervised Day Care
Nurse Training
Placement Maintenance Counseling Services

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**0.00**
Respite Nursing	hourly	0	0.00	0.01	**0.00**	
Specialized Medical Equipment and Supplies Total:						**79000.00**
Specialized Medical Equipment and Supplies	unit	79	1.00	1000.00	**79000.00**	
Certified Nursing Assistant (CNA) Total:						**0.00**
Home Health Aide	hourly	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations Total:						**233200.00**
Environmental Accessibility Adaptations	unit	212	1.00	1100.00	**233200.00**	
Family Training Total:						**15600.00**
Family Training	hours	26	12.00	50.00	**15600.00**	
In Home Shift Nursing Total:						**0.00**
RN	hourly	0	0.00	0.01	**0.00**	
LPN	hourly	0	0.00	0.01	**0.00**	
Medically Supervised Day Care Total:						**95200.00**
Medically Supervised Day Care	hours	7	800.00	17.00	**95200.00**	
Nurse Training Total:						**3840.00**
Nurse Training	hours	8	15.00	32.00	**3840.00**	
Placement Maintenance Counseling Services Total:						**1200.00**
Placement Maintenance Counseling Services	hours	3	8.00	50.00	**1200.00**	
				GRAND TOTAL:		**428040.00**
				Total Estimated Unduplicated Participants:		**700**
				Factor D (Divide total by number of participants):		**611.00**
				Average Length of Stay on the Waiver:		200

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**0.00**
Respite Nursing	hourly	0	0.00	0.01	**0.00**	
Specialized Medical Equipment and Supplies Total:						**184000.00**
Specialized Medical Equipment and Supplies	unit	40	2.00	2300.00	**184000.00**	
Certified Nursing Assistant (CNA) Total:						**0.00**
Home Health Aide	hourly	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations Total:						**190000.00**
Environmental Accessibility Adaptations	unit	190	1.00	1000.00	**190000.00**	
Family Training Total:						**13800.00**
Family Training	hours	23	12.00	50.00	**13800.00**	
In Home Shift Nursing Total:						**0.00**
RN	hourly	0	0.00	0.01	**0.00**	
LPN	hourly	0	0.00	0.01	**0.00**	
Medically Supervised Day Care Total:						**81600.00**
Medically Supervised Day Care	hours	6	800.00	17.00	**81600.00**	
Nurse Training Total:						**5440.00**
Nurse Training	hours	10	16.00	34.00	**5440.00**	
Placement Maintenance Counseling Services Total:						**500.00**
Placement Maintenance Counseling Services	hours	1	10.00	50.00	**500.00**	
				GRAND TOTAL:		**475340.00**
				Total Estimated Unduplicated Participants:		**700**
				Factor D (Divide total by number of participants):		**679.00**
				Average Length of Stay on the Waiver:		204

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost

Respite Total:						**0.00**
Respite Nursing	hourly	0	0.00	0.01	**0.00**	
Specialized Medical Equipment and Supplies Total:						**192418.00**
Specialized Medical Equipment and Supplies	unit	47	1.78	2300.00	**192418.00**	
Certified Nursing Assistant (CNA) Total:						**0.00**
Home Health Aide	hourly	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations Total:						**199360.00**
Environmental Accessibility Adaptations	unit	224	0.89	1000.00	**199360.00**	
Family Training Total:						**16352.50**
Family Training	hours	31	10.55	50.00	**16352.50**	
In Home Shift Nursing Total:						**0.00**
RN	hourly	0	0.00	0.01	**0.00**	
LPN	hourly	0	0.00	0.01	**0.00**	
Medically Supervised Day Care Total:						**85000.51**
Medically Supervised Day Care	hours	7	714.29	17.00	**85000.51**	
Nurse Training Total:						**5712.00**
Nurse Training	hours	12	14.00	34.00	**5712.00**	
Placement Maintenance Counseling Services Total:						**500.00**
Placement Maintenance Counseling Services	hours	1	10.00	50.00	**500.00**	
				GRAND TOTAL:		**499343.01**
				Total Estimated Unduplicated Participants:		**825**
				Factor D (Divide total by number of participants):		**605.26**
				Average Length of Stay on the Waiver:		208

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**0.00**

Respite Nursing	hourly	0	0.00	0.01	**0.00**	
Specialized Medical Equipment and Supplies Total:						**230000.00**
Specialized Medical Equipment and Supplies	unit	50	2.00	2300.00	**230000.00**	
Certified Nursing Assistant (CNA) Total:						**0.00**
Home Health Aide	hourly	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations Total:						**238000.00**
Environmental Accessibility Adaptations	unit	238	1.00	1000.00	**238000.00**	
Family Training Total:						**19800.00**
Family Training	hours	33	12.00	50.00	**19800.00**	
In Home Shift Nursing Total:						**0.00**
RN	hourly	0	0.00	0.01	**0.00**	
LPN	hourly	0	0.00	0.01	**0.00**	
Medically Supervised Day Care Total:						**95200.00**
Medically Supervised Day Care	hours	7	800.00	17.00	**95200.00**	
Nurse Training Total:						**7072.00**
Nurse Training	hours	13	16.00	34.00	**7072.00**	
Placement Maintenance Counseling Services Total:						**500.00**
Placement Maintenance Counseling Services	hours	1	10.00	50.00	**500.00**	
				GRAND TOTAL:		**590572.00**
				Total Estimated Unduplicated Participants:		**875**
				Factor D (Divide total by number of participants):		**675.00**
				Average Length of Stay on the Waiver:		212

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Total:						**233086.08**
Respite Nursing	hourly	4	1663.00	35.04	**233086.08**	

Specialized Medical Equipment and Supplies Total:						**266800.00**
Specialized Medical Equipment and Supplies	unit	58	2.00	2300.00	**266800.00**	
Certified Nursing Assistant (CNA) Total:						**17520.00**
Home Health Aide	hourly	2	438.00	20.00	**17520.00**	
Environmental Accessibility Adaptations Total:						**275000.00**
Environmental Accessibility Adaptations	unit	275	1.00	1000.00	**275000.00**	
Family Training Total:						**22800.00**
Family Training	hours	38	12.00	50.00	**22800.00**	
In Home Shift Nursing Total:						**31538090.50**
RN	hourly	70	6918.00	35.50	**17191230.00**	
LPN	hourly	70	6635.00	30.89	**14346860.50**	
Medically Supervised Day Care Total:						**108800.00**
Medically Supervised Day Care	hours	8	800.00	17.00	**108800.00**	
Nurse Training Total:						**9248.00**
Nurse Training	hours	17	16.00	34.00	**9248.00**	
Placement Maintenance Counseling Services Total:						**500.00**
Placement Maintenance Counseling Services	hours	1	10.00	50.00	**500.00**	
				GRAND TOTAL:		**32471844.58**
				Total Estimated Unduplicated Participants:		**1015**
				Factor D (Divide total by number of participants):		**31991.97**
				Average Length of Stay on the Waiver:		216