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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
This 1915 (c) Persons with Disabilities waiver renewal includes:

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

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

3. Updated cost and participant estimates that reflect historical trends, including an additional sub-category of Overtime Nursing to account for Extended State Plan Services of Intermittent Nursing Services and any overtime pay.

4. Updated performance measures.

In accordance with these substantive changes, this waiver was posted on June 19, 2015 at the website of the Illinois Department of Healthcare and Family Services (HFS), http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx; with public notification on June 19, 2015 in the Illinois Register providing for a minimum of a 30 day feedback period.

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

1. Request Information (1 of 3)

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

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

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IL.0142
Waiver Number:IL.0142.R06.00
Draft ID: IL.018.06.00

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

E. Proposed Effective Date: *(mm/dd/yy)*
07/12/16
Approved Effective Date: 07/12/16

1. Request Information (2 of 3)

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

☐ **Hospital**
Select applicable level of care
○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**
Select applicable level of care
◉ **Nursing Facility as defined in 42 CFR □□440.40 and 42 CFR □□440.155**
If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
Persons with Disabilities
○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

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

- ○ **Not applicable**
- ◉ **Applicable**

Check the applicable authority or authorities:

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

  Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:
  A companion 1915 (b) waiver was approved in 05/28/2014 with an expiration date of 05/31/2019. Since this 1015 (c) does not represent any substantive changes, no concurrent amendment to the 1915 (b) is necessary at this time. The 1915 (b) waiver states how Long-term Services and Supports that are defined in this 1915 (c) renewal are implemented.

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

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

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

  Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
  The Illinois' IL.13-015 1932(a) State plan amendment (SPA) to implement mandatory managed care for the adult aged, blind and disabled populations in Cook County and surrounding border counties was approved for the effective date of May 1, 2011.

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

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

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

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

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

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

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The Medicaid Home and Community-Based Services (HCBS) waiver for persons with disabilities was initially approved by the Centers for Medicare and Medicaid Services (CMS) in 1983. The Department of Human Services, Division of Rehabilitation Services (DHS-DRS) is the operating agency. The Medicaid agency, the Department of Healthcare and Family Services (HFS) is the administering agency, and has delegated the day-to-day operation of the waiver to DHS-DRS through an interagency agreement.

The HCBS waiver is part of a larger program called the Home Services Program (HSP). HSP operates under a state entitlement created as a result of a judicial decision emerging from the McMillan vs. McCrimon case in 1993. Under the entitlement, the program covers services for adults with non-exempt assets up to $17,500. Children under the age of 18 are covered if the family has no more than $35,000 in non-exempt assets. Those that do not meet Medicaid eligibility are funded with the state only monies. Persons may transition in and out of Medicaid eligibility. Services offered are the same for both Medicaid and state funded participants.

DHS, in its Division of Human Capital Development maintains Family and Community Resource Centers responsible for the determination of Medicaid eligibility. This responsibility is managed at these centers through a separate interagency agreement between DHS and HFS.

Persons must also meet the level of care need. A minimum score is required by a standardized assessment which includes a person's mental status, and abilities to perform activities of daily living, and instrumental activities of daily living. Illinois utilizes currently the Illinois Determination of Need (DON) to determine eligibility. As a score on the DON increases, so too, does a person's eligibility for increased service to meet the need. The administration of the DON, which establishes the level of care eligibility, is provided by HSP rehabilitation counselors from one of the 43 DHS-HSP offices.

For waiver participant/consumers not enrolled in managed care, the DHS HSP offices within DRS are staffed with HSP rehabilitation counselors that serve as care coordinators. As stated, the counselors determine HSP and waiver eligibility. They also engage the participant/customer in the development of a participant-centered plan of care (PCP) and work with the participant/customer in monitoring the PCP. Counselors are state employees.

For individuals enrolled in managed care, after the HSP rehabilitation counselor determines level of care eligibility, care coordinators employed by a managed care entity chosen by the waiver participant/consumer engage the participant/customer in the development of a PCP and work with the participant/consumer in monitoring the PCP.

HSP offers a full array of services which include: individual providers (IP) (Personal Care Attendants - Non-Agency Based), homemaker (Agency Based), skilled professional nursing, certified nursing assistants, therapies, adult day care, emergency home response, respite, home delivered meals, environmental modifications, and assistive equipment.

HSP is also a consumer-directed program where most participants hire, supervise, and terminate their own caregivers (personal assistants). The program was designed as an independent living model; under the philosophy that regardless of disabilities or abilities, all persons have the right and responsibility to determine the direction of their lives, have full access to benefits of community living, the opportunity to receive services in the most integrated setting appropriate and to participate fully in life in a meaningful way. DHS acts as a joint employer and serves as the fiscal agent. This responsibility includes issuing payroll checks to workers, withholding FICA and other deductions on behalf of the consumer-directed personal assistants.

DHS-DRS work closely with the Illinois' Centers for Independent Living (CILs). CILs are staffed by persons with disabilities, per Title VII of the Rehabilitation Act. There are twenty-four CILs that recruit and train personal assistants, provide training to waiver participant/customers on how to manage workers and act as a resource to them.

Specifically regarding participant/customers enrolled in managed care, effective February 1, 2013, the State delivers care coordination and all of the waiver services through a mandatory managed care delivery system for those waiver participants enrolled in the Integrated Care Program (ICP). The ICP was initially implemented in the Illinois areas of suburban Cook (outside of the City of Chicago), DuPage, Kane, Kankakee, Lake and Will Counties. In 2013 and 2014, it expanded to other areas of the state including, Chicago, Rockford, Central Illinois, East St. Louis area of Illinois and the Quad cities.

In addition, effective March 1, 2014, the State includes dually enrolled Medicare and Medicaid waiver participants to the managed care delivery system. The Medicare Medicaid Alignment Initiative (MMAI) is operational in the greater Chicago and Central Illinois regions. MMAI or the Managed Long-term Supports and Services (MLTSS) operates through a concurrent 1915(b) waiver. Under the MMAI, Illinois and CMS contracts with Health Plans to coordinate the delivery of,

and be accountable for, all covered Medicare and Medicaid services for participating MMAI enrollees. For those participants who wish to opt-out of the MMAI, long term support services, including waiver services and other Medicaid services, will be provided using the same managed care Health Plans as chosen by the State for MMAI.

3. Components of the Waiver Request

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

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

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

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

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

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

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ( ) **Not Applicable**
- (●) **No**
- ( ) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

Appendix C.

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

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

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

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

I. Public Input. Describe how the State secures public input into the development of the waiver:
Illinois secures public input into the development of this waiver through two separate statements of public notice and input. One form of public notice is electronic through a posting on the HFS website; http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx; with a link to this same website found at the operating agencies' website. For persons that may not have access to the website, a second, non-electronic publication of the waiver renewal was made available. This non-electronic publication is the Illinois Register issued on May 29, 2015 and re-posted on June 19, 2015 to reflect additional substantive changes requiring a public comment period. In the two methods of public notification, the dates of the 30 day public input period were identified. The original 30 day public input period was from May 29, 2015 through June 28, 2015 and due to its re-posting, a new 30 day public input period was from June 19, 2015 through July 18, 2015.

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

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

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

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

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

Specific to Statewide Transition Plan:

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

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

In addition, Illinois hosted six public listening forums at which 175 stakeholders signed attendance sheets and a webinar in which 265 individuals participated.

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

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

K. **Limited English Proficient Persons**. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name:	Classen
First Name:	Kris
Title:	Manager of Long Term Services and Supports and Rebalancing, Bureau of Long Term Car
Agency:	Department of Healthcare and Family Services
Address:	401 S. Clinton Street

Address 2:

City: Chicago

State: **Illinois**

Zip: 60607

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

Fax: (312) 793-5278

E-mail: kristopher.classen@illinois.gov

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

Last Name: Anderson

First Name: Vivian

Title: Chief, Home Services Program

Agency: Department of Human Services, Division of Rehabilitation Services

Address: 100 S Grand Ave East

Address 2:

City: Springfield

State: **Illinois**

Zip: 62762

Phone: (217) 782-2722 **Ext:** ☐ **TTY**

Fax: (217) 557-0142

E-mail: Vivian.Anderson@illinois.gov

8. Authorizing Signature

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

Signature: Teresa Hursey

State Medicaid Director or Designee

Submission Date: Jul 12, 2016

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

Last Name: Hursey

First Name: Teresa

Title: Acting Medicaid Director

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Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings

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

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. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

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.

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:
   The Illinois Department of Human Services, Division of Rehabilitation Services

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

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

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

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

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

   For waiver participants enrolled in MCOs, HFS and the state's External Quality Review Organization (EQRO) provide quality oversight and monitoring of the waiver providers through audits that include record reviews of the enrollee's care plans and each Plan's activities of monitoring quality of services and supports that are provided to the Plan's enrollee participating in the HCBS program. In addition, the state's EQRO include in their record reviews an evaluation of compliance with waiver performance measures and certain components of their contracts related to the waivers. The tool used to evaluate the waiver assurances include:

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

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

Additional EQRO oversight in relationship to the MCO and qualified providers includes a review of initial case manager/care coordinator qualifications and training, annual training and oversight of case manager/care coordinator caseloads.

Service Plan Development—enrollee records are examined to determine that all assessed enrollee needs, goals, and risks are addressed in a person-centered service plan; services are provided according to the plan including engagement of the participant in the development of his/her service plan, goals are set and progress towards goals is indicated; service plans are signed and dated by the enrollee and case manager/care coordinator validating inclusion and agreement; enrollees are routinely contacted by the case manager/care coordinator per applicable waiver requirements; service plans are updated when the enrollee's needs change; and that choice of services and providers was offered to the enrollee. Service plans are also reviewed for completeness, accuracy, and timeliness.

Health, Safety, and Welfare—enrollee records are examined to determine that enrollees are aware of how and to whom to report abuse, neglect, and exploitation; and each enrollee with an independent worker has a backup plan.
Oversight of the MCOs management of critical incidents (CI) and processes is the responsibility of the MA and the EQRO. MCOs submit a detailed monthly report and a quarterly summary report of CIs to the MA. As part of the review and monitoring of compliance processes, the EQRO reviews the policies and procedures for each MCO for reporting CIs prior to accepting enrollment to ensure adequacy of tracking software and follow-up procedures. EQRO subsequently review a sample of CI reports during the post implementation review and during on-going administrative compliance reviews.

Remediation—the EQRO submits a report of findings to HFS, the MA, at the conclusion of each onsite review. The report consists of a summary of findings for each individual record reviewed, and a summary of overall findings detailed by Performance Measure and contractual requirements reviewed.

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

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

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

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

Appendix A: Waiver Administration and Operation

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

   ◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

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

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

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

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

For those waiver participants enrolled in an MCO, the Plans are responsible for care coordination, service plan development and implementation, participant safeguards, prior authorization of waiver services, utilization management, qualified provider enrollment, and quality assurance and quality improvement activities.

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

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

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

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

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

private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

Appendix A: Waiver Administration and Operation

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

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

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

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

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

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The State's Quality Improvement System (QIS) has been modified to assure that the MCO Plans are complying with the federal assurances and performance measures that fall under the functions delegated to them by the MA. The sources of discovery vary, and the sampling methodology for discovery is based on either a 100% review or the use of a statistically valid proportionate and representative sample. The type of sample used is indicated for each performance measure. The MA's sampling methodology is based on a statistically-valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The MA pulls the sample annually and will adjust the methodology

as additional MCOs are enrolled to provide long term services and supports.

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

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

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

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

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

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

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

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☐	☑	☐
Waiver enrollment managed against approved limits	☑	☑	☐

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
1A: # and % of individual findings of non-compliance regarding waiver providers without a Medicaid provider agreement (MPA) on file at the MA that were remediated within 30 days by the OA and MCO. N:# of findings of non-comp. regarding waiver prov. w/out MPA on file at MA that were remed. w/in 30 days by OA and MCO. D:Total # of findings of non-comp. regarding waiver providers w/out MPA on file.

Data Source (Select one):

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
6A: # and % of waiver participants provided choice by the enrollment broker when determining MCO plan selection. N: # of MCO plan waiver participants provided choice by the enrollment broker when determining MCO plan selection. D: Total # of MCO plan waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MA Enrollment Confirmation Reviews

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

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

Data Aggregation and Analysis:

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

Performance Measure:
7A: # and % of PIPs implemented in accordance with timeline in contract requirements. N: # of PIPs implemented in accordance with timeline in contract requirements. D: Total # of PIPs required by contract.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid**	☐ **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:
3A: # and % of waiver program policies submitted by the OA to the MA prior to OA dissemination and implementation. N: # of waiver program policies submitted to the MA prior to OA dissemination and implementation. D: Total # of waiver program policies disseminated and implemented by the OA.

Data Source (Select one):

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

5A: # and % of required MCO reports submitted according to contract requirements. N: # of MCO required reports submitted according to contract requirements. D: Total # of MCO required reports.

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

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

Data Aggregation and Analysis:

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

	Specify:

Performance Measure:
4A: # and % of participant reviews conducted according to the sampling methodology specified in the waiver. N: # of participant reviews conducted according to the sampling methodology specified in the waiver. D: Total # of participant reviews required according to the sampling methodology.

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

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

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:
QIO 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: EQRO	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
2A: # and % of rate methodology changes submitted by the OA that are approved by the MA and submitted for Public Notice prior to implementation. N: # of rate methodology changes submitted by the OA that are approved by the MA and submitted for Public Notice prior to implementation. D: Total # of rate methodology changes implemented.

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

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

Data Aggregation and Analysis:

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

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

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

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

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

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

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

For functions relating to the enrollment broker, MA staff review enrollment activities (including offering of choice), including confirming that enrollment packets are being issued to individuals that are mandatorily required to select an MCO. This review includes confirming the correct enrollment materials (initial enrollment packet, reminder notice and second enrollment notice) were mailed to an individual and within the specified periods of time for such communications and that the enrollment broker attempted a minimum of two outreach calls to encourage the individual to make an active selection and provide education on health plans as needed by the individual. MA staff also monitor call center activities, such as listening to calls that occurred within the call center to ensure the appropriate plan options were presented to an individual in a clear and unbiased manner.

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.
1A: The OA will obtain Medicaid provider agreements. The MCO will work with providers and the OA to obtain Medicaid provider agreements. If not qualified, the provider is dis-enrolled and the OA/MCO provides participant with other available providers. The OA/MCO trains case managers, if needed. Remediation must be completed within 60 days. If remediation is not completed within 60 days, the OA/MCO reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

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

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

4A: MA maintains electronic copies of all primary and alternate client samples provided to QIO and EQRO for reviews to be conducted. QIO/EQRO notifies MA immediately if any discrepancies/issues are identified while onsite.

5A: MA will require completion of overdue reports. Remediation must be completed within 30 days. If remediation is not completed within 30 days, the MCO will submit a plan of correction to MA. The MA follows-up to completion.

6A: The enrollment broker will submit a plan of correction to the MA within 30 days. MA will provide training to the enrollment broker to ensure waiver participants are offered choice of MCO plans. Remediation must be completed within 60 days.

7A: The MCO will complete PIP in accordance with contract requirements. Remediation must be completed within 60 days. If not remediated within 60 days, the MA has the option to implement sanctions.

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)			

	☑		0	59	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			
	☐	**Serious Emotional Disturbance**			

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

Medical determination of a diagnosed, severe disability, which is expected to last for 12 months or for the duration of life.

Other criteria include:
1. Be under age 60 at time of application.
2. Be a resident of the State of Illinois.
3. Be Medicaid eligible.
4. Be at risk of nursing facility placement, as measured by the Determination of Need (DON) Level of Care assessment.
5. Enrolled in one waiver, the waiver that most appropriately meets his or her needs.
6. Ability to be maintained safely in the home at a service cost which does not exceed that of NF care.

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:

The participant must be under the age of 60 at the time of application. After the age of 60, a participant may remain in the waiver as long as the person was assessed prior to the 60th birthday. The participant then has the choice to stay in the Persons with Disabilities waiver or to move into the waiver of the Department on Aging for persons who are elderly (age 60 or older.)

In addition, at any reassessment/redetermination of need, and depending upon the circumstances of the individual, it may be determined that the participant is best served by one of the other state waiver programs. For example, if the participant's condition is such that he/she seems appropriate for the state's HIV/AIDs or Brain Injury waiver, the participant is referred and has the opportunity to be assessed for that program. If the person is found eligible, the participant is subsequently provided with an informed choice and develops a participant centered plan. Recognizing that no one waiver participant can be in two waivers at the same time, and the

participant continues to meet eligibility requirements, the state assures through its policies and procedures that a smooth and seamless transition occurs with no breaks in service.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - ○ **Other**

    Specify:

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

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

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

  Analyses also identified ranges of DON scores, and associated Service Cost Maximum levels (SCM). These ranges were reflective of the severity of impairment and the customer's unmet needs. Analysis determined the level of funding required for each range of DON score, again depending upon level of impairment and need for

service, similar to the case mix system in nursing facilities. Respective SCMs were correlated with similar expenditures at or below those for nursing home placement and assigned by scoring ranges.

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:

Following are Determination of Need scores and associated monthly SCMs

DON Range	Monthly Service Cost Maximum
29-32	$1,869
33-40	$2,147
41-49	$2,389
50-59	$2,858
60-69	$3,360
70-79	$3,632
80-100	$3,904

Appendix B: Participant Access and Eligibility

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

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

Individual cost limits (service cost maximum-SCM) correspond with scores on the Determination of Need

(DON). Eligibility is determined by meeting the minimum State established Level of Care. The range of scores and corresponding SCM is indicated under B-2 a. This amount directly corresponds to the amount the State would expect to pay for the nursing care component of institutionalization if the individual chose institutionalization.

The ranges were determined via research that was conducted by the University of Illinois Chicago, School of Public Health. The purpose of the study was to verify that the DON scoring corresponded with impairment and need. The SCMs were developed by determining institutional costs incurred by individuals with similar DON scores. Although traditionally the OA costs are significantly below corresponding costs, they may not exceed the cost of institutionalization.

If an individual does not meet eligibility requirements as outlined in the 89 Illinois Administrative Code, Section 682, DRS sends the individual a Service Notice that informs the individual why he or she is not eligible. The notice also includes a statement that if the person does not agree with this planned action, that individual can request a hearing. The notice explains how to appeal with the appropriate forms enclosed. The Rights and Responsibilities document explains that all services which were in effect at the time of the appeal will continue until the decision of the appeal is issued. Section F-1 describes the Fair Hearing Process in more detail.

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

- [x] **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:

The SCM for an individual may be exceeded on a monthly basis to meet a temporary increase in need for services as long as the average monthly cost for services during the twelve month period does not exceed the SCM. Such an increase in services shall not last more than 3 months.

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

In addition to the Determination of Need (DON), DRS also uses a more comprehensive needs assessment that addresses multiple areas of needs, including non-waiver services. A complete narrative statement about the customer accompanies this assessment. The HSP offices utilize various community resources to assist the waiver participants to access services needed that are not covered under the waiver.

If an individual has complex medical needs that cannot be served within the allowable SCM, the HSP Counselor may request an exceptional care (EC) rate. The EC rate is determined by HFS and based on higher rates paid in nursing facilities that serve medically complex or deliver special rehabilitative services, similar to that of the customer. If the established SCM for a case is exceeded due to a DHS-DRS approved provider rate increase, the customer may continue to receive the same amount of services even though the SCM will be exceeded.

- [ ] **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	33950
Year 2	34993
Year 3	36068
Year 4	37177
Year 5	38320

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - ( ) **§1634 State**
   - ( ) **SSI Criteria State**
   - (●) **209(b) State**
2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (●) **No**
   - ( ) **Yes**

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

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

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

Select one:

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

Specify percentage:

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

Specify:

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

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

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

Select one and complete Appendix B-5.

- ( ) **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

- [x] **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:
- Other standard included under the State Plan

  Specify:

  The maintenance allowance for the waiver participants equals the maximum income an individual can have and be eligible under 435.217 group.
- The following dollar amount

  Specify dollar amount: If this amount changes, this item will be revised.
- The following formula is used to determine the needs allowance:

  Specify:
- Other

  Specify:

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

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

  Specify:

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

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

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

Specify:

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

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

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

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

Specify:

- ○ **Other**

Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

(*select one*):

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

Specify:

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

(*select one*):

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

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

  Specify dollar amount:
- ◉ **A percentage of the Federal poverty level**

  Specify percentage: 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:

Persons performing level of care evaluations must be a Home Services Program Rehabilitation Counselor employed by the State of Illinois. Qualifications are a Master's Degree with major course work in rehabilitation, counseling, guidance psychology, or a closely related field, plus one-year of professional experience; a registered nurse, licensed in the State; or a Licensed Practical Nurse (LPN) or Vocational Nurse, acting within the scope of practice under State law.

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

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

The necessity for long term care is based on the determined need for a continuum of home and community-based services that ultimately prevent inappropriate or premature placement in a group care facility. The extent and degree of an individual's need for long term care is determined on the basis of consideration of pertinent medical, social and psychological factors as measured by application of the DON (IL488-2069W).

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

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

◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**

○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

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

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

HSP designated staff conduct the level of care evaluations and reevaluations utilizing the Determination of Need as described above.

For participants enrolled in an MCO, the reevaluations will be conducted by the OA.

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

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

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

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

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

The operating agency utilizes WebCM as a computer system that produces several reports including:

1) a "To Do" list that gives counselors a 30-day advance notice of upcoming reassessments and 2) a list of counselors that are not completing redeterminations within the required timeframes. A post-review is also completed during monitoring visits conducted by both the operating agency and the Medicaid agency.

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

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

Records of evaluation and re-evaluation are maintained in the OA's WebCM virtual case management system as well as in each customer's hard copy case file. Each hard copy case file is maintained in the DHS-DRS local office associated with the customer's case. After a case is closed and the requisite three year period has transpired, appropriate hard copy customer cases may be prepared for transfer to the OA's central storage location in Springfield, Illinois. Records in Springfield are maintained until they have met all appropriate guidelines for storage. Staff may request records from the Springfield location when necessary. The electronic version maintained in WebCM is retained indefinitely.

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:
8B: # and % of new waiver participants who had a Level of Care assessment indicating need for NF level of care prior to receipt of services. N: # of new waiver applicants that completed the Level of Care assessment. D: Total # of applicants.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
9B: # and % of waiver participants reassessed, as specified in the approved waiver, through the redetermination process of waiver eligibility every 12 months. N: # of participants reviewed where the participant was reassessed, as specified in the approved waiver, through the redetermination process every 12 months. D: Total # of waiver participants reviewed who had reassessment due.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Reports from OA: Reassessment of eligibility report (WebCM)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **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:
10B: # and % of participants where documentation supports LOC determination. N: # of waiver participants where documentation supports the LOC determination. D: Total # of waiver participants reviewed who had an assessment/reassessment completed.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
11B: # and % of Level of Care determinations using processes and instruments that are applied appropriately and accordingly and made by a qualified evaluator. N: # of Level of Care determinations reviewed using processes and instruments applied appropriately and accordingly and made by a qualified evaluator. D: Total # of Level of Care determinations reviewed.

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

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: semi-annually	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The WebCM data system has built-in edits to reject any assessments that do not meet the level of care criteria for the Determination of Need. It also has built-in reports to determine when assessments are due or overdue. The built-in edits are ongoing. The reports may be run as often as needed.

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

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

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

EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants enrolled in an MCO through consumer surveys and quarterly record reviews. Participants in MCOs are included in the representative sampling.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
8B: 1. LOC is done/corrected upon discovery; 2. If eligible, no additional action; 3. If ineligible, correction of billing and claims; 4. Individual staff training as appropriate. Remediation must be completed within 60 days.

9B: 1. LOC is completed upon discovery; 2. If eligible, no additional correction required; 3. If ineligible, billing and claims adjusted; 4. Individual receives assistance with accessing other supports and services. Remediation must be within 60 days.

10B: If it is discovered that the documentation does not support the LOC, the OA will require a justification from case managers for the eligibility determination. If the justification, is inadequate, the waiver eligibility will be discontinued and the OA will assist the individual with accessing other supports and services. Federal claims will be adjusted and the OA will provide technical assistance or training to case managers. Remediation must be completed within 60 days.

11B: If it is determined that the case manager is not a qualified evaluator, the LOC will be redone by a qualified case manager. If the participant is eligible, no additional correction will be required. If the participant is ineligible, the individual will receive assistance with accessing other supports and services. The OA will also provide training or technical assistance to assure that all case managers meet qualification requirements. Remediation must be completed within 60 days.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

HSP Counselors inform customers of the feasible alternatives available under the waiver and outside of the waiver at the time they apply for services, and during each subsequent reassessment. The Application and Redetermination of Eligibility document and the Appeal Fact Sheet are given to each customer at initial assessment, and at subsequent reassessments.

The Application and Redetermination of Eligibility form contains information regarding the Home Services Program's eligibility requirements and services. The Appeals Fact Sheet contains information regarding the customer's rights to appeal any case decision. The information is reviewed and explained with the customer at initial assessment and during each reassessment. The design of the Application and Redetermination of Eligibility form require customers to initial each section of the document to reflect an understanding of the material provided prior to a formal signature. Subsequent presentation of this information is noted in the customer's case file following each reassessment.

Customer preference is verified when the Service Plan (IL488-1049) is signed by the customer. By signing this form, customers acknowledge that they have been given a choice between home care and institutional/nursing facility care, are choosing to remain in the home, and agree that the services described in the service plan will assist them in remaining there.

The Mini Mental State Exam (MMSE) is a component of the Determination of Need, and is administered during each assessment/reassessment to assist in determining whether or not the customer can appropriately direct their care. If so determined, customers may choose between service providers, and may direct and train their caregiver. If it is determined that the customer does not have this capacity and no responsible family member or guardian is available, then a provider such as homemaker or home health agency can be used.

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

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

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

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

For participants enrolled in an MCO, the Plans will maintain the forms.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
The entities under contract with the Operating Agency serve as access points and are integrated into the communities. In some areas, the HSP Counselors interact on a daily basis with a wide variety of individuals with varying backgrounds, cultures, and languages. The HSP Counselors have resources available to communicate effectively with persons of limited English profiency in their community, including bilingual staff as needed, interpreters, and translated forms. Interpreter services are provided at no cost to consumers.

For participants enrolled in an MCO, the Plan shall make all written materials distributed to English-speaking enrollees, as appropriate, available in Spanish and other prevalent languages, as determined by the MA. Where there is a prevalent single-language minority within the low income households (5% or more such households) where a language other than English is spoken, the Plans' written materials must be available in that language as well as in English.

Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Adult Day Care
Statutory Service	Homemaker
Statutory Service	Individual Provider (Personal Assistant - Non Agency)
Statutory Service	Respite
Extended State Plan Service	Home Health Aide
Extended State Plan Service	Occupational Therapy
Extended State Plan Service	Physical Therapy
Extended State Plan Service	Speech Therapy
Other Service	Environmental Accessibility Adaptations
Other Service	Home Delivered Meals
Other Service	In-Home Shift Nursing
Other Service	Intermittent Nursing
Other Service	Personal Emergency Response System
Other Service	Specialized Medical Equipment

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Adult Day Care (ADC) is direct care and monitoring of customers in a community-based setting for any portion of a 24-hour day for the purpose of promoting social, physical, and emotional health and well-being and offering an alternative to an institutional setting. ADC services are provided only when the social, emotional, and physical needs of the customer cannot be met in the home through other available services."

By definition, Adult Day Care is to be offered as a least restrictive alternative to nursing facility care or care within the home. In addition, Adult Day Care facilities are subject to the new federal HCBS rule, and their compliance with the rule will be assessed and enforced through the State's HCBS statewide transition plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount, duration, and scope of services is based on the Determination of Need assessment conducted by the HSP Counselor and the service cost maximum determined by the DON score. DRS will provide a maximum of two one-way trips per day.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Transportation
Agency	Adult Day Care

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Care

Provider Category:
Agency
Provider Type:
Adult Day Transportation
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
89 Ill Adm Code 686.100
Verification of Provider Qualifications
Entity Responsible for Verification:
OA
Frequency of Verification:
Every 3 years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Care

Provider Category:
Agency
Provider Type:
Adult Day Care
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
89 Il 686.100
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
Every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service:

Homemaker

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope)*:
Services consisting of general household activities (meal preparation and routine household care) and personal care provided by a trained homemaker, when the individual regularly responsible for these activities is unable to manage the home care for him or her self and is unable to manage a personal assistant. This service will only be provided if personal care services are not available or are insufficient to meet the care plan or the consumer cannot manage a personal assistant. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service will be provided if personal care services are not available or are insufficient to meet the care plan or the consumer cannot manage a personal assistant. The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.

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

- [ ] **Participant-directed as specified in Appendix E**
- [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	Homemaker

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Homemaker

Provider Category:
Agency
Provider Type:
Homemaker
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
89 Il. Adm. code 686.200
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
At time of enrollment and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Personal Care
Alternate Service Title (if any):
Individual Provider (Personal Assistant - Non Agency)

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Independent Providers (IP), non-agency based personnel, assist with eating, bathing, personal hygiene, and other activities of daily living in the home and at work (if applicable). These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include housekeeping chores, such as bed making, dusting, vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the consumer rather than the consumer's family. The IP meets state standards for this service. Personal care will only be provided when it has been determined by the case manager that the consumer has the ability to supervise the IP. The IP is the employee of the consumer. The state acts as the fiscal agent for the consumer. The Healthcare Worker Background Check (HCWBC) Act (225 ILCS 46) requires background checks for home health agencies. The HCWBC act specifies who must be screened. Providers that must be screened include: homemaker agency staff, adult day care staff, and home health agency staff.

IPs are hired independently by the customer and excluded from the act due to grass roots advocacy efforts of the disability community. Other providers exempt from the act include independently hired licensed providers including: RNs, LPNs, and therapists. The Department of Financial and Professional Regulations in accordance with their licensure requirements covers licensed providers. Independent CNAs are covered through the Health Care Worker Registry.

The Illinois State Police maintains a database of criminal convictions in Illinois. Certain agencies providing direct services to individuals are required by law to request criminal conviction history information as a condition of employment. The State offers customers the option to conduct the background checks without cost when hiring the IP. Homemaker services are always provided through an agency. Homemaker agencies are subject to the Act and therefore must conduct criminal background checks on all homemakers. The Act lists the convictions that disqualify them from service agency employment.

DRS gives participant/customers the option to conduct HCWBCs on personal assistants, at no cost to the customer. DRS provides information to the customers on how to request HCWBC. The results are returned directly to the customer. The Illinois Department of Public Health verifies that home health agencies comply with the HCWBC Act during licensure reviews. DRS verifies that homemakers and adult day care agency staff have HCWBC when they conduct compliance reviews. HFS verifies compliance during onsite monitoring reviews for home health, homemaker, and adult day care agencies.
consumer.

Personal Assistant IPs are the only individual providers who are neither licensed nor certified, and they are checked annually at the time of redeterminations to ensure they continue to meet waiver requirements. All other providers are agency providers, all of whom have some sort of licensing requirement. In addition, the OA and the Department on Aging conduct reviews every two years of several types of providers to check payment records at every level from workers turning time in to submitting bills to the OA. In addition, all other criteria for being an approved provider are checked, such as credentials of the director, training records, and physical location. Finally, all providers are required to update their Medicaid provider agreement at least every two years.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount, duration, and scope of services is based on the determination of need assessment conducted by the HSP Counselor and the service cost maximum determined by the DON score. Independent Provider (Personal Care Attendants - non Agency based) cannot be duplicative of services offered under EPSDT.

The customer's legally-responsible family members (89 Ill. Adm. Code 676.30) cannot be paid as care providers.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal Assistant

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Individual Provider (Personal Assistant - Non Agency)

Provider Category:
Individual
Provider Type:
Personal Assistant
Provider Qualifications

License *(specify)*:
In order to be employed by a customer as a Personal Assistant (PA), an individual must meet one of the following categories: 1) be 14 or 15 years of age and not employed during school hours, have an employment certificate and meet all other requirements of the Child Labor Law, and will be supervised by an adult 21 years or older; 2) be 16 to 18 years of age and enrolled in school (must not be employed during school hours); 3) be 17 to 18 years of age and not enrolled in school; or 4) be an adult, 18 years of age or older.

The individual must have a Social Security number and provide HSP documentation of this number. The individual must have provided the customer with at least two written or verbal recommendations from present or former employers, a recommendation from a Center for Independent Living (CIL), or, if never employed, references from at least two non-relatives. The individual must be able to communicate with the customer and follow directions to the satisfaction of the customer and counselor. The individual must have previous experience and/or training that is adequate and consistent with the specific tasks required for safe and adequate care of the customer and if the customer has a contagious infectious disease, have a physician, health care institution (i.e., hospital, nursing home, home health agency), or CIL certify, in writing, that he/she has the knowledge of precautionary procedures for the control of contagious infectious diseases, if it is anticipated that he/she will come into contact with bodily fluids, or be evaluated by a licensed Registered Nurse to determine that he/she has knowledge of those procedures. The individual must complete all relevant forms required to work as an Individual Provider under the Home Services Program, some of which also require the customer's signature. The individual shall provide services to the customer in accordance with the Customer's Service Plan and he/she shall comply with the Program's policies and procedures related to the Electronic Visit Verification system and the Home Services Program Overtime Policy. The individual shall submit bi-monthly Time sheets listing actual hours worked each pay period, which is verified by the customer and in accordance with the hours authorized on the Customer's Service Plan.

Certificate *(specify)*:
N/A

Other Standard *(specify)*:
89 IL Adm. Code 686.10

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*

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

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

By definition, Respite services are provided for no more than 240 hours per year. This can be used for 10, 24-hour days or the hours can be spread out throughout the year. HSP Respite is provided only in the home with the exception of Adult Day Care which can serve as one of the Respite services. Nothing remotely institutional is allowed to be used for Respite Services. The IT payment system has edits on what services may be provided in Respite, tracks the number of Respite hours provided by participant calendar year, and will not allow more than 240 hours to be billed during that time period.

Respite services can be provided by a fairly wide range of providers in terms of required credentials and in terms of skills. This reflects the very wide range of needs and services provided for the program's participants. Credential reviews for different provider types are done by different agencies, and the frequency of some credential reviews is dictated by a variety of statutes. The Nurse Practice Act, for example, dictates the frequency and content of credential reviews for LPNs and RNs. Several other laws address the content and frequency of credentialing for therapists and home health aides. There is even a statute which requires homemaker providers to get background checks, and now there is a similar but separate law for personal assistants. These laws are then implemented by the IL Department of Professional Regulation and the IL Department of Public Health.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual

Provider Type:
Home Health Aide

Provider Qualifications

License *(specify)*:
N/A

Certificate *(specify)*:
N/A

Other Standard *(specify)*:
210 ILCS 45/3-206

Verification of Provider Qualifications

Entity Responsible for Verification:
DRS
Frequency of Verification:
At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
RN
Provider Qualifications
License *(specify):*
210 ILCS 65
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Homemaker
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
89 Il. Admin. code 686.200
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
Every three years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
210 ILCS 55
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
Personal Assistant
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
89 Il. Admin. code 686.10
Verification of Provider Qualifications
Entity Responsible for Verification:
The customer verifies inititally and DRS and HFS verify during monitoring.
Frequency of Verification:
Prior to being hired

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Adult Day Care
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*

N/A
Other Standard *(specify):*
89 Il. Admin. code 686.100
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
Every three years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
LPN
Provider Qualifications
License *(specify):*
120 ILCS 65
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Home Health Aide

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Extended State Plan Service - Home Health Aide are are part of the treatment plan outlined by the attending physician. These services include the use of simple procedures as an extension of therapeutic services; ambulation and exercise; personal care; household services essential to healthcare at home; assistance with medications that are ordinarily self-administered; and reporting changes in a participant's condition and needs to the registered nurse or appropriate therapist.

The provided services are as defined in 42 CFR 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.

The services are provided by an individual that meets Illinois standards for a Certified Nursing Assistant (CNA) through completion of an approved course. The CNA must provide a copy of the certificate of completion or be listed on the Illinois Department of Public Health Registry website.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services provided are in addition to any services provided through the State Plan. The amount, duration, and scope of services is based on the determination of need assessment conducted by the HSP Counselor and the service cost maximum determined by the DON.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:

Home Health Agency
Provider Qualifications
License *(specify):*
210 ILCS 55
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
At the time of enrollment and annually

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Home Health Aide
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
210 ILCS 45/3-206
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
At the time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Extended State Plan Service
Service Title:
Occupational Therapy

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Extended State Plan Service - Occupational Therapy is a medically prescribed service identified in the service plan that is designed to increase independent functioning through adaptation of the tasks and environment. The service is provided by a licensed occupational therapist that meets Illinois licensure standards. Occupational therapy through the waiver focuses on long-term habilitative needs rather than short-term acute restorative needs.

Services may be approved under the waiver if the individual is no longer eligible for therapies under the state plan, but continues to need long-term habilitative services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan. The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.

Services provided through the state plan are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Under the State plan, the first 60 days following discharge from a hospital or long term care facility do not require prior approval when services are intitiated within 14 days of discharge. Services may be provided under the waiver when the individual does not meet eligibility requirements for the state plan services.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Occupational Therapist

Provider Qualifications

License *(specify)*:
225 ILCS 75

Certificate *(specify)*:
N/A

Other Standard *(specify)*:
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
DRS

Frequency of Verification:
At time of enrollment and annually

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Home Health Agency

Provider Qualifications

License *(specify)*:
210 ILCS 55

Certificate *(specify)*:
N/A

Other Standard *(specify)*:
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
DRS

Frequency of Verification:
At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Physical Therapy

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Extended State Plan Service - Physical Therapy is a medically prescribed service identified in the service plan that utilizes a variety of methods to enhance an individual's physical strength, agility and physical capacities for activities of daily living. The service is provided by a licensed physical therapist that meets Illinois licensure standards.

Physical therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs. Physical therapy can be used to train personal assistants to perform exercises and/or maintenance activities within the customers home.

Services may be approved under the waiver if the individual is no longer eligible for therapies under the state plan, but continues to need long-term habilitative services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan. The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.

Services provided through the state plan are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Under the State plan, the first 60 days following discharge from a hospital or long term care facility do not require prior approval when services are intitiated within 14 days of discharge. Services may be provided under the waiver when the individual does not meet eligibility requirements for the state plan services.

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

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

☑ **Provider managed**

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

☐ **Legally Responsible Person**

☑ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

225 ILCS 90

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

225 ILCS 55

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:
At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Extended State Plan Service

Service Title:
Speech Therapy

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Extended State Plan Service - Speech Therapy is a medically prescribed speech and/or language based service identified in the service plan that is used to evaluate and/or improve a customer's ability to communicate. The service is provided by a licensed speech therapist that meets Illinois licensure standards. Speech therapy through the waiver focuses on long-term habilitation needs rather than short-term acute restorative needs.

Services may be approved under the waiver if the individual is no longer eligible for therapies under the state plan, but continues to need long-term habilitative services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan.

The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.

Services provided through the State plan are of a curative or rehabilitative nature and demonstrate progress

toward short-term goals. State plan services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long-term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Under the State plan, the first 60 days following discharge from a hospital or long-term care facility do not require prior approval when services are initiated within 14 days of discharge. Services may be provided under the waiver when the individual does not meet eligibility requirements for the State plan services.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Speech Therapist

Provider Qualifications

License *(specify)*:
Speech and Language Pathologists are licensed pursuant to the requirements in (225 ILCS 110/) Illinois Speech-Language Pathology and Audiology Practice Act.
Each applicant for a speech-language pathology or audiology license shall file an application with the Department of Financial and Professional Regulation-Division of Professional Regulation (Division), on forms provided by the Division. The application shall include certification of a master's or doctoral degree from a program approved by the Division; passage of the PRAXIS examination or certification from the American Speech-Language-Hearing Association or from the American Board of Audiology. Exam scores shall be submitted directly to the Division from the testing service. The application shall also include certification of completion of the equivalent of 9 months of full-time supervised professional experience; and the required fees set forth by the Department. The Division, upon recommendation of the Board, will also accept a Certificate of Clinical Competence in Speech-Language Pathology or Audiology awarded by the American Speech-Language-Hearing Association's Clinical Certification Board or certification in audiology from the American Board of Audiology.

To the extent that the SLT services being or to be provided to children fall within the EPSDT portion of Illinois' state plan, waiver staff ensure that the participant uses State Plan services instead, as applicable.

Certificate *(specify)*:
N/A

Other Standard *(specify)*:
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

210 ILCS 55

Certificate *(specify):*

N/A

Other Standard *(specify):*

N/A

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:**

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

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

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

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

All Environmental Modification providers meet the approval of the customer and counselor; submit a completed 1413 A − Waiver Program Provider Agreement for Participation in the Illinois Medical Assistance Program form; submit a completed W-9 Request for Taxpayer Identification Number and Certificate; carry a minimum of $500,000 in liability insurance, and provide DHS-DRS with a copy of the Certificate of Insurance verifying current coverage; provide proof of appropriate current contractor licenses, as applicable; perform all modifications so that they meet the standards established by the Environmental Barriers Act, the Illinois Accessibility Code [71 ILCS 400] and local zoning ordinances and codes; and obtain proper building permits as required by local municipalities.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The cost of environmental modification, when amortized over a 12 month period and added to all other monthly service costs, may not exceed the service cost maximum (89 Ill. Adm. code 679) established for the customer's case. In addition, the total cost for purchase of all environmental modifications and assistive equipment purchase, rentals, and repairs shall not exceed $25,000 every 5 years (89 Ill. Adm. Code 686.705(d)).

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	Environmental Modification Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations

Provider Category:
Individual
Provider Type:
Environmental Modification Contractor
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
N/A
Other Standard *(specify):*
89 Il. Adm. code 686.600
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
Prior to project initiation

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Home Delivered Meals

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
Prepared food brought to the clients residence that may consist of a heated luncheon meal and a dinner meal (or both) which can be refrigerated and eaten later. This service is designed primarily for the client who cannot prepare his/her own meals but is able to feed him/herself. This service will be provided as described in the service plan and will not duplicate those services provided by personal care services or homemaker provider. Meals provided shall not constitute a full nutrition regimen (participants are not receiving 3-meals per day).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.

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

- [ ] **Participant-directed as specified in Appendix E**
- [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	Home Delivered Meals Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:
Home Delivered Meals Provider
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
By Health Department where vendor is located
Other Standard *(specify):*
89 Il. Adm. Code 686.500
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
DRS obtains a copy of the HDM agency's Public Health certificate on an annual basis to verify that the provider meets state and local health codes.

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:**

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

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

Service Definition *(Scope):*

Nursing services are provided within the scope of the State's Nurse Practice Act by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the state and are not otherwise covered through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).

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

The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.

The HSP Service Plan includes the type of service(s) to be provided to the customer, the specific tasks involved, the frequency with which the specific tasks are to be provided, the number of hours each task is to be provided per month, and the rate of payment for the service(s). Each type of nursing is a specific service with specific codes. The service plan and its contents are maintained in the program's IT system and payments made on behalf of customers are edit checked against the service plan. In addition, staff are trained as to what type of nursing service is most cost effective and/or most appropriate for a given situation. With the Electronic Visitation Program now used for all individual providers, the presence of more than one provider serving a participant at the same time is allowed for training situations of one provider to another. Nonetheless, this occurrence is placed on an exception report for the explicit purposes of trying to prevent duplicates. Other reports are also produced to detect duplicates and most customers who use nurses extensively also have a special time keeping system which would detect duplication. Finally, if a participant receives a State Plan or EPSDT service during the same pay time period as a waiver provider, the FFP claim is rejected. Rejects are closely reviewed.

Overtime Nursing Service was listed as a new service in error. This type service is neither necessary nor desirable. Overtime will be billed and claimed with the use of supplemental codes added to appropriate hcpc codes, i.e. there would be a single supplemental code for overtime hours, but it could be added to the hcpc codes for any of the possible individual type service providers, thus allowing the billing, reporting and tracking of overtime. On its revised application, the State will remove overtime nursing as a service but will adjust its waiver utilization projections to reflect new overtime and travel reimbursement requirements under the FLSA.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Registered Nurse

Provider Qualifications

License *(specify)*:
ILCS 65

Certificate *(specify)*:
N/A

Other Standard *(specify)*:
N/A

Verification of Provider Qualifications

Entity Responsible for Verification:
DRS

Frequency of Verification:
At time of enrollment and annually

Appendix C: Participant Services

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

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

Provider Category:
Agency

Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
ILCS 55
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
At time of enrollment and annually

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
LPN
Provider Qualifications
License *(specify):*
ILCS 65
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Intermittent Nursing services are provided within the scope of the State's Nurse Practice Act by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the state and are not otherwise covered through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).

Intermittent nursing is used for purposes of evaluating customer needs (including assessments and wellness checks)and monitoring.

Intermittent nursing is paid in two-hour increments and is different from other waiver nursing services that are paid hourly. Hourly nursing services are for ongoing and routine care needs.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.

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

The HSP Service Plan includes the type of service(s) to be provided to the customer, the specific tasks involved, the frequency with which the specific tasks are to be provided, the number of hours each task is to be provided per month, and the rate of payment for the service(s). Each type of nursing is a specific service with specific codes. The service plan and its contents are maintained in the program's IT system and payments made on behalf of customers are checked against the service plan. In addition, staff are trained as to what type of nursing service is most cost effective and/or most appropriate for a given situation. With the Electronic Visitation Program now used for all individual providers, the presence of more than one provider serving a participant at the same time is allowed for training situations of one provider to another. Nonetheless, this occurrence is placed on an exception report for the explicit purposes of trying to prevent duplicates. Other reports are also produced to detect duplicates and most customers who use nurses extensively also have a special time keeping system which would detect duplication. Finally, if a participant receives a State Plan or EPSDT service during the same pay time period as a waiver provider, the FFP claim is rejected. Rejects are closely reviewed.

Services provided through the state plan are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Under the State plan, the first 60 days following discharge from the hospital or long term care facility do not require prior approval when services are initiated within 14 days of discharge. Services may be provided under the waiver when the individual does not meet eligibility requirements for the state plan services.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Intermittent Nursing

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify)*:
ILCS 55
Certificate *(specify)*:
N/A
Other Standard *(specify)*:
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Intermittent Nursing

Provider Category:
Individual
Provider Type:
LPN
Provider Qualifications
License *(specify)*:
ILCS 65
Certificate *(specify)*:
N/A

Other Standard *(specify)*:
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
At time of enrollment and annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Intermittent Nursing

Provider Category:
Individual
Provider Type:
Registered Nurse
Provider Qualifications
License *(specify)*:
ILCS 65
Certificate *(specify)*:
N/A
Other Standard *(specify)*:
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Personal Emergency Response System

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
PERS is an electronic device that enables certain individuals to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. Trained professionals staff the response center. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision. This service has two components: an intial installation fee and a monthly service fee.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergency Home Response

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Emergency Home Response
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*

N/A
Other Standard *(specify):*
89 Il. Adm. code 686.300
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
At time of enrollment and every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Medical Equipment

HCBS Taxonomy:

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

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

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

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

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

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

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

benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.

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

- [ ] **Participant-directed as specified in Appendix E**
- [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	Pharmacies
Agency	Medical Suppliers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment

Provider Category:
Agency
Provider Type:
Pharmacies
Provider Qualifications
License *(specify):*
225 ILCS 85
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
Providers must maintain at least $500,000 in liability insurance. A copy of the insurance certificate is obtained by the HSP Counselor and maintained in the customer's case file. Within 30 calendar days of customer's receipt of equipment, the counselor must make a home visit to verify that the equipment has been delivered to the customer or repaired, and to ensure customer satisfaction. Written verification from the customer shall be required to verify receipt and satisfaction.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment

Provider Category:
Agency

Provider Type:
Medical Suppliers
Provider Qualifications
License *(specify):*
225 ILCS 51
Certificate *(specify):*
N/A
Other Standard *(specify):*
68 Il. Adm. Code 1253
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
Providers must maintain at least $500,000 in liability insurance. A copy of the insurance certificate is obtained by case manager and maintained in customer's case file. Within 30 days of customer's receipt of equipment, the counselor must make a home visit to verify that the equipment has been delivered to the customer or repaired, and to ensure customer satisfaction. Written verification from the customer shall be required to verify receipt and satisfaction.

Appendix C: Participant Services

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

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

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

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

There are 43 DHS Home Service Program (HSP) local offices, staffed with HSP rehabilitation counselors that directly oversee the care provided to persons with disabilities under this program. The counselors are state employees.

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

Both homemakers and case managers have both initial and ongoing training requirements in the contract and/or rate agreement with their agency. Workers who have been inactive would require retraining with new workers because inactive providers have to be re-enrolled and must meet the base criteria to be enrolled.

Appendix C: Participant Services

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

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

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

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

The Healthcare Worker Background Check (HCWBC) Act (225 ILCS 46) requires background checks for home health agencies. The HCWBC act specifies who must be screened. Providers that must be screened include: homemaker agency staff, adult day care staff, and home health agency staff.

Individual Providers (IP) hired by the customer are excluded from the act due to grass roots advocacy efforts of the disability community. Other providers exempt from the act include independently hired licensed providers including: RNs, LPNs, and therapists. The Department of Financial and Professional Regulations in accordance with their licensure requirements covers licensed providers. Independent CNAs are covered through the Health Care Worker Registry.

The Illinois State Police maintains a database of criminal convictions in Illinois. Certain agencies providing direct services to individuals are required by law to request criminal conviction history information as a condition of employment. The State offers customers the option to conduct the background checks without cost when hiring the PA. Homemaker services are always provided through an agency. Homemaker agencies are subject to the Act and therefore must conduct criminal background checks on all homemakers. The Act lists the convictions that disqualify them from service agency employment.

The OA currently assists customers in making informed choices about the individual providers they hire by providing the opportunity and encouragement for them to obtain background checks. The scope of the background checks is state-level. Background checks can be requested for any private provider paid through the Home Services Program. Background checks continue to be an optional service available through HSP. An independent contractor, Mind Your Business, can be used at the customer's discretion and provides a statewide criminal background check. The report is mailed only to the customer and the cost does not in any way affect the services they receive through HSP. This system will soon be replaced by "IMPACT," a new provider enrollment system through which mandatory background checks will be done. At the present time, HSP does not have the authority to do its own background checks. "Impact" through a contractual relationship with LexisNexis will provide criminal background checks, sanction information and whether or not a provider has ever been banned as a provider from another state. In addition we also have questions within IMPACT that are self-disclosures by providers.

The Illinois Department of Public Health verifies that home health agencies comply with the HCWBC Act during licensure reviews. DRS verifies that homemakers and adult day care agency staff have HCWBC when they conduct compliance reviews. HFS verifies compliance during onsite monitoring reviews for home health, homemaker, and adult day care agencies.

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

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

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

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

The Illinois Department of Public Health (DPH) maintains the Health Care Worker Registry. Screenings must be conducted on all certified nursing assistants prior to providing care. DPH verifies compliance for home health agencies during licensure reviews. Registry checks are maintained in the customer's file. HFS reviews files

during monitoring reviews at home health agencies to assure documentation in file if the customer is being served by a CNA.

The registry includes certification status for nurse aides as well as history of substantiated abuse, neglect or exploitation while employed in a nursing facility. Employers also report on the results of criminal background checks to the registry, including disqualifying convictions. For more information on the Health Care Worker Registry see: http://www.idph.state.il.us/nar/home.htm.

Homemaker agencies are not currently required to conduct registry screenings. Individual Providers are not listed on the registry. However, if the person has previously worked as a CNA and if abuse, neglect or misappropriation of funds was substantiated, the information would be on the registry. HSP offers customers the option and information on how to conduct the registry checks. This would allow the customer the opportunity to screen the worker for history of abuse, neglect, or criminal conviction that disqualified him or her from working in an institution or other health care position covered by the Act.

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.

  Parents or step-parents of minor children, or legally responsible family members, and minor children (per 89 Ill. Adm. Code 676.30) cannot be paid as a care provider. Minor children may provide a waiver service only after they have been granted a work permit by the local school district, and as long as they meet all provider qualifications, and when no other appropriate service provider can be located. They cannot provide services to their parent. The case file must contain documentation that a serious and ongoing effort is being made to locate another appropriate services provider; or the HSP Counselor has determined, based on documentation in the case file, that the family member is the most appropriate service provider due to the care involved, or the circumstances. Payment will not be made for services to a minor by the child's parent (or step-parent), or to an individual by that person's spouse. Family members must meet the same standards as providers who are unrelated to the individual. Time sheets are signed by the customer to verify that the services were rendered.

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

  Also, the customer completes an annual personal assistance evaluation where the customer officially evaluates the PA's work performance, and verifies that services were provided to the customer, which may include changing providers or utilizing a provider from the next highest level of care (i.e., utlizing a homemaker.)

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

  The HSP Counselor also verifies that services are provided in accordance with the customer's service plan. During reassessments the Counselor notes the customer's general condition, hygiene and cleanliness, considers the customer's nourishment status, notes any odors in the house as well as cleanliness of the home, etc. If discrepancies are identified, the HSP Counselor determines whether or not care is being provided at the appropriate level. Based upon these observations the HSP Counselor may follow up with an unannounced home visit, arrange for a nursing assessment to determine whether the customer is receiving the proper level of care: and if not, change the level of service to a homemaker.
- **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:

Approximately 85% of the providers in this program are personal assistant providers who are hired directly by the customer. Anyone that meets the personal assistant requirements and is selected by the customer may become a provider. Customers hire, train, supervise and have the ability to fire their personal assistant workers. Other services such as homemaker and adult day care go through a Request for Qualifications process, which is open at all times. Eligible providers are approved and enrolled. Home health providers, such as nurses and therapists, must meet the individual licensing requirements under the Illinois Department of Financial and Professional Regulations (DFPR). The State Medicaid agency enrolls all willing and qualified providers that are chosen for waiver services.

Customers recruit and choose their own personal assistants. The customer hires and fires PAs, supervises their work and is responsible for approving hours of work of the PA before submission to the state for reimbursement. Illinois Centers for Independent Living offer personal assistant training programs. Some also maintain a list of trained providers, while others offer training to the customer on how to hire, fire and manage the personal assistant. All customers are given the name of the centers in their area. This information is included as a component of the "customer's packet". It is made available to the customer at initial assessment, and will be provided if subsequently requested by the customer. The customer may contact the local center for a listing of potential personal assistants if they are not able to locate a provider on their own.

DHS uses any homemaker agency that meets the Request for Qualifications requirements and who chooses to enter into a rate agreement. A rate agreement is a binding agreement between DRS and the provider that establishes service parameters and rates. The MA also signs the rate agreement as part of its oversight of rates. The rate agreement is in addition to the Medicaid Provider Agreement--a three-party agreement that must be signed by the provider, DRS, and HFS. Homemaker agencies may learn about working with DHS through the Illinois Home Care Council (IHCC). This organization is a statewide, nonprofit, trade association that promotes the delivery of quality health care and supportive services in a variety of home living environments in the state of Illinois. Through the organization, homemaker agencies can learn of the potential of enrolling as a waiver provider with DHS and HFS to provide homemaker services to program customers. The Request for Qualifications is an ongoing opportunity for interested homemaker agencies to request an application for services. Eligible providers are approved and enrolled, if they meet required qualifications and are willing to enter into a rate agreement with DHS.

Adult Day Care providers enter into agreements with DHS in the same manner, as do homemaker agencies. DHS accepts agencies that have been approved providers by the Department on Aging.

Plans are required to contract with any willing and qualified waiver provider. Qualifications may be enhanced by the Plans.

1. The State will institute an “any willing provider” contractual clause that will require Plans to offer contracts to any willing provider that meets quality and credentialing standards. After the initial contracting period, Plans will be allowed to impose a known quality standard and to terminate contracts with underperforming providers.

In addition to this any willing provider standard, Plans must continually meet the following network adequacy requirements throughout the term of their contracts.

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

Adult Day Care
Homemaker
Home Delivered Meals
Home Health Aides
Nursing Services

Occupational Therapy
Speech Therapy
Physical Therapy
Specialized Medical Equipment and Supplies

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

The following requirements apply for the remaining HCBS waiver services:

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

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

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

All provider qualifications and requirements are found verbatim on the DHS Website, at http://www.dhs.state.il.us/page.aspx?item=27896. That website includes links to provider enrollment instructions, licensure and certification requirements, instructions for becoming a provider, relevant administrative rules, and contact information.

The page linked above contains information for providers for an array of DHS programs. Provider enrollment instructions are contained in the "IMPACT" link. There is also a "Become a Provider" link, and there are links for "Licensure and Certification" and for "Rules." Contact information is available in a link for "Rehabilitation Services Provider Information" under the "Provider Information by Division" heading.

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:
14C: # and % of enrolled licensed waiver service providers that continue to meet applicable licensure requirements (same provider types as 13C). N: # of enrolled licensed waiver service providers that continue to meet applicable licensure requirements. D: Total # of enrolled licensed waiver service providers.

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
13C: # and % of newly enrolled licensed waiver service providers who meet initial licensure standards (Includes: social workers, clinical psych., licensed counselors, home health agencies, LPN, RN, OT, PT, ST, special medical equipment providers). N: # of newly enrolled licen. waiver service providers who meet initial licensure standards. D:Total # of newly enrolled licen. waiver service providers

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

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

Data Aggregation and Analysis:

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

Performance Measure:
15C: # and % of newly enrolled certified waiver service providers who meet initial certification standards (Note: this includes Home Health Aide, Home Delivered Meals, Day Habilitation, Pre-Vocational, and Supported Employment providers). N: # of newly enrolled cert. waiver service providers who meet initial certification standards. D: Total # of newly enrolled cert. waiver service providers.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
16C: # and % of enrolled certified waiver service providers who continue to meet applicable certification requirements (same provider types as 15C). N: # of enrolled certified waiver service providers that continue to meet applicable certification requirements. D: Total # of enrolled certified waiver service providers.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
12C: # and % of individual findings regarding provider qualifications non-compliance that were remediated within 60 days by the OA and MCO. N: # of individual findings regarding provider qualifications non-compliance that were remediated within 60 days by the OA and MCO. D: Total # of individual findings regarding provider qualifications non-compliance.

Data Source (Select one):

Other
If 'Other' is selected, specify:
MCO Reports: Provider Qualification Reports

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
17C: # and % of newly enrolled non-licensed/non-certified wvr svc. providers, by provider type, who meet initial wvr provider qualifications (Includes: ADC, homemaker, EHR). N: # of newly enrolled non-lic./non-cert. wvr svc. providers reviewed, by provider type, who meet initial wvr provider qual. D: Total # of newly enrolled non-lic./non-cert. wvr svc. providers reviewed, by provider type.

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

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:
18C: # and % of non-lic./non-cert. waiver svc. providers, by provider type, who continue to meet waiver provider qualifications (same provider types as 17C). N: # of enrolled non-lic./non-cert. waiver svc. providers reviewed, by provider type, who continue to meet waiver svc. provider qualifications. D: Total # of enrolled non-lic./non-cert. waiver svc. providers reviewed, by provider type.

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

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

	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: All providers reviewed every 2 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:
20C: # and % of non-licensed/non-certified waiver service providers, by provider type, who continue to meet waiver provider qualifications (same provider types as 19C). N: # of enrolled non-lic./non-cert. waiver serv. providers reviewed, by provider type, who continue to meet waiver provider qualifications. D: Total # of enrolled non-lic./non-cert. waiver serv providers reviewed, by provider type.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
19C: # and % of newly enrolled non-licensed/non-certified waiver service providers by provider type, who meet initial waiver provider qualifications (Includes: PA & Env. Acc. Mod.). N:# of newly enrolled non-lic./non-cert. waiver providers reviewed, by provider type, who meet init. waiver provider qualifications. D: Total # of newly enrolled non-lic./non-cert. providers reviewed, by provider type.

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

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

Data Aggregation and Analysis:

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

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

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

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

Performance Measure:
21C: # and % of existing case managers who meet waiver provider training requirements. N: # of existing OA and MCO case managers reviewed who meet waiver provider training requirements. D: Total # of existing OA and MCO case managers reviewed.

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

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

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

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

Data Aggregation and Analysis:

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

	☐ **Other** Specify:

Performance Measure:
23C: # and % of existing homemaker agencies that meet waiver provider training requirements. N: # of existing homemaker agencies reviewed that meet waiver provider training requirements. D: Total # of existing homemaker agencies reviewed.

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

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

Performance Measure:
22C: # and % of new or previously inactive case managers who meet provider training requirements.N: # of new or previously inactive OA and MCO case managers reviewed who meet waiver provider training requirements. D: Total # of of new or previously inactive OA and MCO case managers reviewed.

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

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

Data Source (Select one):

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

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

Data Aggregation and Analysis:

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

Performance Measure:
24C: # and % of new or previously inactive homemaker agencies who meet waiver provider training requirements. N: # of new or previously inactive homemaker agencies reviewed who meet provider training requirements. D: Total # of new or previously inactive homemaker agencies reviewed.

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Before an MCO can provide waiver services, it first must pass a pre-implementation Long Term Services and Supports (LTSS)-specific readiness review conducted by the MA's EQRO. The EQRO reports review results to the MA; an MCO must pass this review successfully in order to obtain the MA's approval. As an extra measure to ensure compliance, the MA requires the EQRO to conduct a post-implementation readiness review approximately 2-3 months after an MCO begins providing services. The EQRO reports these review results to the MA.

A minimum of once every 3 years, the MA's EQRO conducts a full compliance audit for each MCO. The EQRO reports the audit's results to the MA; an MCO must pass this audit successfully in order to continue its contract with HFS. In addition, the EQRO visits all MCOs annually to perform reviews targeting areas of compliance and conduct focus studies as appropriate. The EQRO reports the results from these annual visits to HFS.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
12C: The OA obtains provider qualifications documentation. The MCO will work with providers and the OA to obtain documentation. If not qualified, the provider is dis-enrolled and the OA/MCO provides participant with other available providers. The OA/MCO trains case managers, if needed. If remediation not completed within 60 days, the OA/MCO reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

13C:Provider will be notified by the OA of lacking documentation. Receipt of respective provider licensure documentation or disenroll. Remediation within 30 days.

14C:Remove as Medicaid provider in MMIS and require the respective provider licensure documentation be provided; Change of provider; Training for OA/MCO case managers. Remediation within 60 days.

15C:Provider will be notified by the OA of lacking documentation. Receipt of respective provider certification documentation or disenroll. Remediation within 30 days.

16C:Remove as a Medicaid provider in MMIS and request the respective provider certification documentation; Change of provider; Training for OA case managers. Remediation within 60 days.

17C:Provider will be notified by the OA of lacking documentation. Receipt of respective documentation or disenroll. Remediation within 30 days.

18C:Remove as Medicaid provider in MMIS and require respective provider documentation be submitted; Change of provider; Training for OA/MCO case managers. Remediation within 60 days.

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

20C:Remove as Medicaid provider in MMIS and request a receipt of respective provider documentation; Change of provider; Training for OA/MCO case managers. Remediation within 60 days.

21C:Completion of case manager training; Moratorium of new PD cases to non-certified OA/MCO case managers. Remediation within 60 days.

22C: Completion of case manager training; Moratorium of new PD cases to non-certified OA/MCO case managers. Remediation within 60 days.

23C: Complete the training requirements. OA must submit a plan for how to assure training requirements are continually met. Remediation within 60 days.

24C: Complete the training requirements. OA submit a plan for how to assure training requirements are continually met. Remediation within 60 days.

ii. Remediation Data Aggregation

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

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

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

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

☑ **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

Program eligibility is based upon scoring of an assessment tool, the Determination of Need. A service cost maximum is the total amount of funding available for services and is derived from the assessment score. This funding covers services provided in a given month. In certain instances, persons with severe disabilities who are in need of exceptional medical care may qualify for an exceptional care rate if they may be safely maintained in the home at a cost not greater than that of institutional care.

Determination of Need

The Determination of Need (DON) and the mini-mental state examination (MMSE) are the assessment tools used to determine an individual's non-financial eligibility for HSP services based on the individual's impairment in the completion of the Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and the individual's need for supports not met by unpaid caregivers or other resources. This assessment is made to determine whether or not the individual is at imminent risk of institutionalization without services, and therefore eligible for placement in a nursing facility or community-based services through the waiver.

Service Cost Maximum

Each customer has a Service Cost Maximum (SCM) or limit as to how much they can receive in services. This amount is based on each client's total DON score. Individuals with complex disabilities and/or fragile medical situations can obtain an Exceptional Care Rate (ECR) using essentially the same methodology to compute the rate as is used for such care in a nursing facility. Each client's service plan is built individually to meet each participant's needs and preferences. The resulting actual cost of services is almost always significantly lower than the SCM or ECR. The SCMs and ECRs are redetermined on a yearly basis.

One-time costs such as PERS installation, environmental modifications, and specialized medical equipment are not included in monthly SCMs and ECRs. Rather they are included in the five-year cost maximum for such services.

Sometimes during the interval between redeterminations or the initial evaluation and redeterminations, the needs of the participant change so significantly that the existing service plan will not work. In cases where the existing plan can be modified to accommodate the change and remain under the SCM or ECR, a service addendum is written which provides for the new or different services needed. This plan is "extended" if the situation is expected to last until the next redetermination, but otherwise the addendum stays in place for a limited amount of time. In cases where the needed change to the existing plan would cause the client to exceed the SCM or ECR, a new DON needs to be done if the change will last for more than a few weeks. For a very short period the SCM can be exceeded as long as the extra spending will be made up when the service plan returns to normal. Because of the instability of some participants' disabilities or medical situations, it is not uncommon for participants to have multiple addendums between redeterminations. It is less common for new redeterminations to have to be done much earlier than planned because of a major change.

The PWD Waiver has Participant:Employer Budget Authority so the participant has a Service Cost Maximum rather than a budget. The Determination of Need (DON) is used to determine this spending limit. After the SCM is set, the service plan is developed together with the participant for an amount no greater than the SCM. The OA has always used Master's level staff because both setting the level of care through the DON and establishing the service plan require a great deal of judgment. This same judgment is used when participant circumstances change and a change in the service plan is warranted. As discussed in Question #25, as long as the changes are within the SCM, changes can be made strictly to the service plan. If the changes are significant, a new DON and entirely new service plan are required. As described in Question #25, the procedures for making changes to the service plan, which is what actually changes the participant's approved spending, are very clear and explicit.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Home Services Program 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:

A Home Services Program Rehabilitation Counselor employed by the State of Illinois. Qualifications are:
1) Master's Degree with major course work in rehabilitation, counseling, guidance psychology, or a closely related field, plus one-year of professional experience.
2) Registered Nurse, licensed in the State;
3) Licensed Practical Nurse or Vocational Nurse, acting within the scope of practice under State law.

For participants enrolled in an MCO, qualifications for the care coordinators vary within each of the Plans. Participants are assigned to specific care coordinators based on individual need and identified risk. At minimum, qualifications include the following license or education level:
1) Registered Nurse (RN),
2) Licensed Clinical Social Worker (LCSW);
3) Licensed Marriage and Family Therapist (LMFT);
4) Licensed Clinical Professional Counselor (LCPC)
5) Licensed Professional Counselor (LPC);
6) PhD;
7) Doctorate in Psychology (PsyD);
8) Bachelor or Masters prepared in human services related field;
9) Licensed Practical Nurse (LPN)

The MCO care coordinators are required to complete 20 hours of training, initially and annually, as specified in the MMAI contract. MCO care coordinators must be trained on disciplines specific to the type of HCBS Waiver Enrollee they are providing service.

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

(a) Supports and information available to participant/customer

OA Process:

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

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

process is a Participant Centered Plan of Care in which the plan is one that is owned and agreed to by the participant/customer.

Written materials pertaining to the waiver are being updated to ensure language in all materials informing the waiver participant/customer of his/her rights comport with HCBS rules. These documents include statements in the Home Care Consumer Bill of Rights and a Person Centered Goal addendum to the service plan. Language used in these written materials is being tested in order to ensure that it is plain and understandable. Language in these informational materials includes updated rights statements pertaining to choice, goals and desires. In addition, the language in these documents articulate the ability of the participant/customer to include all persons chosen by the participant/customer to be included at all informational gathering, assessment and reassessment meetings. Language states that times of these meetings should occur at times and locations convenient with the understanding that to fully assess participant/customers' needs, it is to be completed in their home environment and that the waiver participant/customer is in essence the driver of the participant/customer centered plan development. Language states that the conversation between the waiver participant/customer and the care coordinator is to be goal-centered.

The written documentation in the development of the Participant/customer Plan of Care should indicate that the waiver participant/customer exercised choice in the decision-making process. Evidence in the Participant/Customer Plan of Care should clearly outline the life goals, desires and supports; identified by the waiver participant/customer.

As mentioned above, the Home Care Consumer Bill of Rights which was enacted August 15, 2014 into State law outlines the State's commitment to assuring the rights of all home care consumers. It emphasizes their participation in planning, self-determination, choice, dignity and individuality and is to be provided to and discussed with, the participant/customer at all assessments and sessions where planning occurs.

Also as mentioned, the Care Coordinator completes a Person Centered Goal Addendum to the Participant Centered Plan of Care. This form states that the Participant Centered Plan of Care that is the result of the care planning conversations and assessments, address waiver participant/customer's needs with programs and services provided under the waiver and those outside the waiver. If identified by the customer, the Plan of Care may include include housing, recreation, and employment, spiritual and emotional supports.

The most commonly used waiver service is the personal assistant. Participant/customers are supported in identifying, training and supervising their personal assistant(s). These processes and actions further demonstrate the lead role of the participant/customer in plan development and in plan implementation.

MCO Process:

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

A critical element of the process is the professional practice of the MCO Care Coordinator. The engagement and inclusion of the participant/customer and those that he/she designates to be included in the process requires training and expertise by the Care Coordinator. The MCO assessment tools and those given to them by the OA, prompt the care coordinators to ensure that all areas of a holistic assessment are captured and that the goals, desires and needs of the participant/customer are reflected. The resulting Plan of Care should include all participant/customer needs, desires, goals and vision meet the participant/customer expectations, to the maximum extent, based upon available waiver and non-waiver programs and services.

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

minimize or eliminate risk. Through the assessment and care planning process, the participant/customer's goals and the strengths and barriers to achieving these goals are identified.

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

OA Process:

Following determination of program eligibility, the OA Counselor and the participant/customer converse, usually by phone, schedule the assessments and reassessments. During this conversation, the time of the actual meeting is scheduled at the convenience of the participant/customer and other parties that the participant/customer wishes to have included. The face-to-face assessment visits are conducted in the participant/customer's residence as this is most convenient to the participant/customer and leads to a more accurate assessment of the participant/customer. Changes to location are to meet the participant/customer's needs.

MCO Process:

Similarly, once program eligibility is established, the service plan is developed by the Plans' care coordinators in collaboration with the waiver participant/customer and/or their representative following the same expectations as those set by the OA for the state's care coordinators. Similarly, the MA has set the same expectations regarding setting of the assessments and reassessments at the convenience of the participant/customer. The service plan is developed by the Plans' case managers in collaboration with the waiver participant/customer and/or their representative. At the time of the assessment and service planning process the participant/customer is encouraged to include the person(s) of their choosing to attend a face-to-face visit with their assigned case manager. The date and time of this face-to-face visit is collaborated on based on the participant/customer's preference. The face-to-face assessment visits are conducted in the participant/customer's residence as this is most convenient to the participant/customer and leads to a more accurate assessment of the participant/customer. Changes to location are to

meet the participant/customer's needs and are not for the convenience of Plan staff.

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

OA Process:

Service needs are identified based on the Determination of Need (DON) assessment tool and the mini-mental state exam (MMSE). This tool determines that customer's level of impairment in activities of daily living and whether the participant/customer's individual care needs are met by family members or other supports. This tool is then used to update the service plan.

In (a) above, the process in all assessments is to have the participant/customer articulate his/her needs, goals, and desires. Using this as a basis for a holistic approach to care coordination, the assessment of the participant/customer's situation and circumstances identifies all factors contributing to quality of life and the participant/customer's ability to live independently in the community. The Determination of Need (DON) assessment tool which includes a mini-mental state exam is used as the foundation to identify needs associated with ADLs and IADLs. In addition, an addendum, based on the interview assessment is added to the participant/customer centered service plan that incorporates the participant/customer's strengths, capacities, needs, preferences, desired outcomes, and goals in relationship to issues such as housing, employment, recreation and emotional health. The needs assessment is an addendum to the service plan. Care coordinators are trained to encourage the participant/customer to direct the assessment as much as possible and to discuss potential risks and work together to develop a plan that will minimize or mitigate/eliminate the risk.

MCO Process:

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

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

c) Informing customer of services available under the waiver.

OA Process:

As part of the assessment and reassessment process, the care coordinator and participant/customer discuss the array of services, regardless of funding sources, which are available to them and to which they are eligible. The array of services also includes the participant/customer's goals that may not be met by a waiver or other formal service. It is the care coordinator's responsibility to explain all service options to the participant/customer, including, but not limited to waiver services. Care coordinators are required to go through training that includes training on comprehensive care coordination. This training outlines services that are available through other state and federal agencies, local entities, and charitable organizations.

In addition, during these meetings, participant/customers are informed of their rights. An appeals document is given to customers at each plan development, application, reassessment, and at any time a service is changed. However, care coordinators are encouraged to work out any participant/customer concerns prior to filing an appeal.

MCO Process:

The participant/customer is informed by the Plan of the covered waiver services:

• At the initial face-to-face visit by the case manager; in conjunction with the review of the member handbook/inserts;

• Annually when the Plan's case manager reviews the member handbook/inserts with the participant/customer;
In addition, the care coordinators are to encourage the participant/customer to take the lead in plan development and to identify services that might not be included in the Plan, but reflect additional goals and desires of the participant/customer. The Participant Centered Plan that emerges from this conversation is to reflect waiver services and informal services.

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

OA Process:

The comprehensive assessment takes into consideration the consumer's goals, desires and other needs, including health care needs as described above in (b). Waiver services that are included in the Participant Centered Plan of Care must be necessary and meet an unmet care need of the individual, and/or provide relief to the primary unpaid caregiver. Services should mitigate risk, be cost-effective, and be the most economical services available. The participant/customer centered service plan that results from the conversation between participant/customer and OA Counselor should be one in which the participant/customer agrees. Subsequently, the participant/customer and the OA Counselor approve and sign the service plan. In addition, the participant/customer is given an informed choice of providers of waiver services and he/she has discretion in approving service providers, including the personal care attendant, if this service is identified in the plan of care.

Part of this holistic approach to Participant Plan of Care development, includes a conversation regarding medical/health care needs. It is recognized looking at a systems approach, that unaddressed needs with physical health impact the delivery of long-term services and supports, as well as challenges and inconsistencies in the delivery of long-term services and supports impact health status. While the responsibility of coordination is on the participant/customer, it is up to the care coordinator to raise the critical issues and help the participant/customer problem solve with all service needs.

MCO Process:

Comprehensive assessments are developed by the MCOs. The MCO contract specifies expectations for waiver clients, including content of and purposes for Enrollee Care Plans and HCBS Waiver service plans (for enrollees receiving HCBS Waiver services).

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

Strength of the MCO model is the actual coordination of health care needs and long-term services and supports. MCOs develop a holistic Participant Centered Plan of Care and are responsible for monitoring its implementation, along with the participant/customer.

On behalf of HFS, the EQRO reviews assessments as part of its pre-implementation record review, onsite post-implementation record review as well as in quarterly record reviews to make sure the assessments meet contractual requirements.

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

OA Process:

A comprehensive assessment is completed at the initial assessment and at least annually thereafter. The participant centered plan of care that is developed includes waiver and non-waiver services the participant/customer is receiving, regardless of funding source. Plans of care are shared with providers and they are trained to report any changes in the

participant/customer situation to the care coordinator including a disruption of other, non-waiver services. Identifying all agencies in the home on the plan of care assists the provider agencies to know who should be in the home and during what times, providing an additional level of quality assurance.

MCO Process:

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

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

OA Process:

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

MCO Process:

The Plan case manager is responsible for the execution of the service plan, which includes monitoring the provision of waiver services and risk mitigation strategies. The participant/customer's role is clearly defined in the care plan, and the participant/customer is responsible for actively participating and providing feedback. The Participant's Bill of Rights, as described above, will be added to the documents provided to participant/customers receiving waiver services in WY 1.

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

OA Process:

The HSP counselors, RNs, and LPNs conduct re-determinations of eligibility on an annual basis to review and/or revise plans of care with the participant/customers or at times when there is a significant change. The plan of care is designed to meet all needs of the individuals as identified on the DON and to identify other needs or risks that the persons may have.

If the customer's living situation has changed to the extent that services need to be revised, the HSP Counselor may complete a temporary service plan addendum that modifies the level of care until the next reassessment is completed. If there are new needs or if the new cost of services exceeds the SCM, the HSP Counselor will complete a new reassessment in the home.

As stated previously, the participant/customer is given appeal rights, if not satisfied with the amount or type of services authorized. However, the HSP counselor is encouraged to have a conversation with the participant/customer to try and resolve service plan issues. Participant/customers have the right to appeal any decision made by the HSP Counselor concerning their case. Customers are also informed of their responsibilities including: completing and submitting necessary personal and contact information to facilitate timely eligibility determination and provision of services; how to properly complete, sign, and/or submit necessary documentation in accordance with program guidelines and assisting DRS with gathering the information necessary to determine eligibility; and reporting all changes in circumstances which may affect eligibility or continued eligibility for services to DHS, as soon as known.

MCO Process:

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

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

The participant/customer is in the center of the care/service planning process. The Plan case management staff completes a comprehensive assessment to identify the participant/customer's strengths, needs, formal and informal supports based on information provided by the participant/customer or representative. The participant/customers have an active role in choosing the types of services and service providers to meet those needs. The case manager obtains the waiver participant/customer's signature of agreement on the service plan and offers the waiver participant/customer a choice of providers to fulfill the services

The Plan's case manager is responsible for providing clear direction to the participant/customer regarding appeal rights whenever a reduction, termination, or suspension in service(s) occurs. The appeal rights are summarized in the service plan that the participant/customer signs at the initial assessment, and each reassessment thereafter. If the member appeals, the services will remain intact until the appeal process is exhausted, including the State Fair Hearing. The member handbook/inserts that are provided to, and reviewed with the participant/customer, also provide information on appeal rights and processes. After each comprehensive assessment is completed, in which the member's current status and needs are identified; a new service plan will be completed. During the assessment, and as needed in-between assessments, the Plan's case manager educates the participant/customer to call the case manager to request a change in the plan if the participant/customer's situation or needs change in-between assessments. The participant/customer is educated to notify the case manager any time there is a change in their living or medical situation that may affect their need for services. Service plans can be created or adjusted in-between assessments to meet the member's immediate needs. Whenever there is a significant change in level of service needs or functioning (for example, hospitalization significantly impacting the participant/customer's level of functioning), a new assessment will be completed and additional services provided as needed.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

As our counselor/care coordinators assess for participant/customer needs, they are evaluating current participant/customer risks. They work with the participant/customer to identify the resources and strategies to mitigate these risks through the linkage and delivery of services, ultimately to prevent institutionalization and for the customer/participant to be successful in community residency. These risks are identified in the assessment tools utilized and in during the conversations and interviews that are critical elements of the process. For example, if the participant/customer is at nutritional risk, through the use of a home care worker or home delivered meals may be part of the Participant Centered Plan of Care to mitigate this risk.

The care coordinator and participant/customer discuss a whole range of domains beyond those that waiver services

may mitigate the risk. These domains include issues that impact the success of the waiver service or any other formal or informal supports employed to mitigate the risks. This systemic approach reviews many risk factors. These risk factors could encompass behavioral health concerns of the participant/customer that may include depression, anxiety, abuse of alcohol or other substances including illegal substances and medications. Risk factors may also include the role of caregivers, physical health, and the occurrences and risks of falls.
Part of this risk mitigation discussion includes the consequences of negative choices. This discussion is maintained between the OA Counselor and the participant/customer during initial assessment, and subsequent reassessments. The customer is assessed with respect to risks and potential risk factors, and the State's ability to address any identified risks by the service plan. Severity of impairment is determined through OA Counselor's interview of the customer and is also supported by clinical information.

Provider agencies are required to to have a policy for an all hazards disaster operations including, but not limited to, medical emergencies, home or site-related emergencies, participant/customer-related emergencies, weather-related emergencies and vehicle/transportation emergencies. For example, in-home service agencies train their home care aides to make additional meals for storage and reheating during times of inclement weather just in case a home care aide cannot access a participant due to inclement weather.

Every service plan must have a backup plan, which is documented in the service plan on the signature page. The Back-up Plan utilizes programs, services and resources identified by the participant/customer and care coordinator. The Back-up Plan is a companion document to the Participant Centered Plan of Care. Consequently, all risks that are identified and mitigated though the use of formal and informal long term services and supports need to be stated in the Back-up Plan.

The Back-up Plan also articulates who has the responsibilities of mitigating or reducing risk. Just as a Participant Centered Plan of Care indicates who has responsibility, so too does the companion Back-up Plan of Care.

If a risk or need is being mitigated by a provider agency, then the agency is responsible to assure that there is a back-up plan in place for their piece of the Participant Centered Plan of Care. This is a requirement that is built into the agreement between DRS and the provider. If the provider is a personal assistant, the case manager works with participant/customers to develop a back-up care plan that could include using a non-paid caregiver, another personal assistant or an agency. Customers are encouraged to obtain two personal assistants that are familiar with their needs, so that there is always a trained back-up caregiver available. Another option is to use a trained personal assistant from a listing provided by a local Center for Independent Living (CIL).

Lastly, when a participant/customer has lost a personal assistant and is going through the interviewing and hiring process to obtain another personal assistant, DRS, as the OA, immediately authorizes an increase in the service plan to obtain a homemaker agency. Obtaining a homemaker agency, while a customer is in between personal assistants, helps maintain continuity of care as the customer finds a new personal assistant.

MCO Process:

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

OA Process:

Approximately 85% of the providers in this program are personal assistants that are hired and trained by the participant/consumer. HSP Counselor/care coordinators assist consumers in identifying potential personal assistant providers as well as traditional providers. When a personal assistant is chosen, the counselor gives the participant/customer a customer packet that includes information on self-direction including: Personal Assistant Handbook, Customer's Rights and Responsibilities document, Personal Assistants Standards forms and Medicaid Provider Agreement. HSP Counselors receive intensive training on the array of services provided by the waiver. Additionally, counselors receive the rates and fees table that lists all service descriptions.

In some rural areas, despite the relatively high wages paid to PAs, the State has difficulty maintaining providers due to transportation issues and, in times of good employment, due to the presence of other well-paying industry jobs. In these situations, OA counseling staff can provide ideas and other potential resources for participants to find available workers, and, of course in all instances the State works to ensure continued access to potential Pas for its clients.

If a traditional provider is chosen, the customer may be provided with a list of providers from the local Center for Independent Living, if a list is available. The customer may utilize the list as a resource, but he/she is not required to chose a provider from it. Each service provider is also encouraged to have its own brochures and advertising material available upon participant/customer or care coordinator request. Participant/customers and families are encouraged to visit ADS providers before choosing that provider.

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

MCO Process:

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

It is the Plan's care coordinator's role to provide information about the available services and service providers and to answer any questions of the participant/customer. The Plan assists the participant/customer by supplying qualified and contracted provider information relevant to the services available in the member's service area that are selected by the participant/consumer member. Participant/customers always have first choice on the providers they select to meet their needs. Plan care coordination staff informs and supports the participant/customer in selecting a provider to meet their needs particularly, if the participant/customer does not have a preferred provider identified. The Plan maintains a current list of qualified and contracted service providers in the participant's geographic area which is made available to participant/customers upon request. The participant/customer is also educated of the availability of the Plans' provider list found on their website.

MCO Plans must have contracts in-place with a sufficient number of such Providers within each county in the Contracting Area to assure that the Affiliated Providers served at least eighty percent (80%) of the number of Participant/customers in each county who were receiving such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) of such Providers, so long as such Providers accept

Contractor's rates, even if one (1) served more than eighty percent (80%) of the Participant/customers, unless the Department grants Contractor an exception. It is the State's goal that this will insure choice on behalf the member participant/customer.

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):

While the OA and the MCOs have day-to-day responsibility for the completion and approval of service plans, service plans are subject to oversight from the MA. This oversight is accomplished through the MA's Quality Improvement System using a proportionate sampling methodology having a 95% confidence level and a 5% margin of error for both the OA and the MCOs. The methodology is adjusted when new MCOs are enrolled to ensure proportionate sampling across all operating entities. Once the MA selects the random sample, it is provided to the MA's reviewing entity responsible for monitoring the OA (a Quality Improvement Organization, or QIO) and MCOs (an External Quality Review Organization or EQRO).

For the OA, the QIO determines a review schedule, based on the random sample and performs annual onsite record reviews to assess compliance with the service plan performance measures as well as with all applicable state and federal requirements. Reports of findings are shared with the OA along with recommendations for amelioration of individual case findings and/or needed systemic improvement(s). The OA has a specified length of time to respond to the HFS reports. Information related to MA oversight of the service planning process is also shared between the MA and OA during quarterly meetings between HFS and DHS-DRS.

For the OA, the MA selects a statistically valid sample for conducting onsite record reviews to assure compliance with federal assurances. The MA uses a proportionate sampling methodology with a 95% confidence level and a 5% margin of error. Once the MA selects the sample, it is provided to the MA's Quality Improvement Organization (QIO), the entity that assists HFS in its monitoring of OAs. The QIO determines a review schedule based on the sample and performs onsite record reviews to assess compliance with the service plan performance measures. The QIO sends reports of findings to the MA, which then sends the reports to the OA as well as to the review sites. The OA is required to approve review sites' corrective action plans. Review sites are required to remediate findings within required timelines. The MA verifies remediation of findings on a random basis. Information is shared during quarterly meetings between HFS and DHS-DRS.

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

The EQRO sends a report of findings to the MA and the MCOs and the MCOs are required to remediate these findings as recommended within the required timelines. Remediation activities are reported to the MA, at least quarterly on both an individual and systemic basis. The MA also has regular and periodic meetings with the MCOs during which quality improvement activities are reviewed, and remediation approaches discussed.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

○ **Other schedule**

Specify the other schedule:

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

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

Specify:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

(a) The entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare

OA Process:

The primary avenue to monitoring the participant's needs and service planning is the completion of the comprehensive assessments with the participant. The case management staff and the HSP Quality Assurance Unit staff are primarily responsible for the monitoring of the implementation of the service plan. Case managers meet with participant/customers, annually, at a minimum. Additionally, when problems are reported, case managers respond by meeting as needed or on a more frequent basis.

MCO Process:

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

(b) The monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

OA Process:

Case managers monitor service plans throughout the service period as follows:
For customers using homemaker and home health agencies, case management staff reviews monthly progress reports, submitted by the agencies. Monthly reports from agencies may trigger telephone contact with the customer or a face-to-face meeting. When issues are found, case managers follow-up on a case-by-case basis and may adjust the service plan as needed.

For customers who have personal assistants, case management staff reviews billings twice a month to ensure services are provided in accordance with service plan. If there are issues with the provision of services, there is case

management follow-up with the customer to rectify the situation.

Case management staff review and follow-up on unusual incident reports. When issues are found they are addressed on a case-by-case basis and the service plan may be amended as needed.

Non-waiver services are identified at the time of eligibility and each reassessment, and are documented on the HSP Needs Assessment. This document is included in the DRS Web CM System and the WebCM is designed to remind the Case Manager to follow-up when unmet needs are documented on the Needs Assessment.

Follow-up is usually done by referring the customer to alternate services. When monitoring the service plan, the DRS Quality Assurance unit reviews unmet needs and the documented follow-up by the case manager.

The HSP Quality Assurance Unit conducts reviews of a sample of service plans in each HSP office annually.

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

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

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

When problems are detected in service plans by the DRS Quality Assurance unit, they are documented and shared with the case managers who develop corrective action plans to address the issues.

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

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

The HSP Quality Assurance Unit develops a report and shares the report with the individual HSP office and the DRS Regional office. The individual HSP offices are then responsible for making individual corrections.

On an annual basis, the HSP Quality Assurance Unit develops a statewide summary report of monitoring activities. The reports are shared during quarterly Quality Improvement meetings with HFS to discuss trends, patterns, remediation and quality improvement methods on a system-wide level.

Process for OA and MCO:

The MA provides oversight monitoring and specific monitoring of activities that include randomly selected participant interviews and record and service plan reviews to verify the following:

Services are furnished in accordance with the service plan and meet participant needs - During the on-site visits, HFS interviews participants to verify that services are delivered according to the service plan and meet participant's needs. HFS reviews case notes to identify changes in service needs and whether they resulted in service plan revisions if warranted. Worker timesheets are reviewed to ensure the services delivered are consistent with the

service plan.

Participant access to waiver services is identified in the service plan - HFS compares the DON assessment of needs and available supports to the participant's service plan to ensure that unmet needs identified on the assessment are addressed.

Participants exercise free choice of providers - HFS verifies that the participant has signed the service plan, which indicates the participant was given:
1) The choice of in home care or nursing facility services and,
2) Participated in choice of services and providers.

The participant centered plan of care includes a statement that the participant/customer received a copy of the service plan and the HSP "Application and Redetermination of Eligibility Agreement". The agreement contains information such as: customer rights and responsibilities abuse and neglect reporting, choice and services. The participant signs this agreement and initials each section indicating that the document was explained and the participant understands the information. During participant interviews, HFS asks participants whether they are allowed to choose their own worker.

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

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

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

All findings are reported to DRS for remediation. Discussion of trends and patterns is incorporated into quarterly Quality Improvement meetings.

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

Through its contract with the EQRO, the MA assures that the Plans are complying with contract requirements and the waiver assurances for monitoring service plans. Participants enrolled in the plan will be included in the overall representative sampling methodology used for evidentiary reporting of assurances. The Plans will be required to report event and other data to the MA where sampling methodology is 100%. MA oversight will include onsite or desk audit validation in these areas.

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

b. Monitoring Safeguards. *Select one:*

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

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
28D: # and % of OA and MCO survey respondents in the sample who reported they receive services they need when they need them. N: # of OA and MCO survey respondents who reported they receive services when needed. D: # of OA and MCO survey respondents in the sample.

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

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

	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% of the population selected randomly by region
	☐ **Other** Specify:	

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

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

Performance Measure:
26D: # and % of OA and MCO participants' service plans that address all participant needs identified by the assessment. N: # of OA and MCO service plans reviewed that address all participant needs identified by the assessment. D: Total # of OA and MCO service plans reviewed.

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

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

	Specify:	

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

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

Data Aggregation and Analysis:

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

☐ **Other**
Specify:

Performance Measure:
27D: # and % of OA and MCO participants' service plans that address all health and safety risk factors identified by the assessment. N: # of OA and MCO service plans reviewed that address all participant health and safety risk factors identified by the assessment. D: Total # of OA and MCO service plans reviewed.

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
25D: # and % of OA and MCO participants' service plans that address all personal goals identified by the assessment. N: # of OA and MCO service plans reviewed that address all personal goals identified by the assessment. D: Total # of OA and MCO service plans reviewed.

Data Source (Select one):

Other
If 'Other' is selected, specify:
MCO Reports; EQRO Reviews

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

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

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

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

Data Aggregation and Analysis:

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

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:
32D: # and % of OA and MCO participants who received annual contact by their case manager in an effort to monitor service provision and to address potential gaps in service delivery. N: # of OA and MCO participants reviewed who received annual contact by their case manager. D: Total # of OA and MCO participants

reviewed.

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

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

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

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

		95%
☑ **Other** Specify: EQRO/MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
30D: # and % of OA and MCO participants' service plans that were signed and dated by the waiver participant and the case manager. N: # of OA and MCO service plans that were signed and dated by the waiver participant and the case manager. D: Total # of OA and MCO service plans reviewed.

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

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

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

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

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

☐ **Other**
Specify:

Data Aggregation and Analysis:

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

Performance Measure:
29D: # and % of service plans that were implemented prior to authorization by the OA and MCO with remediation within 60 days. N: # of service plans that were implemented prior to authorization by the OA and MCO with remediation within 60 days. D: Total # of services plans reviewed by the OA and MCO that were implemented prior to authorization.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports to MA on Delegated DHS Appeals Process; HSP QA Audit Reports

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

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

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

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

Data Aggregation and Analysis:

Responsible Party for data	**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: MCO	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
31D: # and % of OA and MCO participants who have PA or other IP svcs whose svc. plan included back up plans. N: # of OA and MCO participants reviewed who have PA or other IP svcs whose svc. plan included back up plans. D: Total OA and MCO participants reviewed who have personal assistant or other independently employed services.

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

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

	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

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

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:
33D: # and % of OA and MCO waiver participants who have their Service Plan updated every 12 months. N: # of OA and MCO waiver participants reviewed who have their Service Plan updated every 12 months. D: Total # of OA and MCO waiver participants with service plans due during the period reviewed.

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

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

	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
35D: # and % of OA and MCO waiver participants that received updates to service plans when participants needs changed. N: # of OA and MCO waiver participants reviewed that received updates to service plans when participants' needs changed. D: Total # of OA and MCO waiver participants reviewed whose needs changed.

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

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

Data Source (Select one):

Other
If 'Other' is selected, specify:
OA Reports: HSP QA Audit Reports

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

Data Aggregation and Analysis:

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

Performance Measure:
34D: # and % of overdue Service Plan 12 month renewals that were remediated within 30 days by the OA and MCO. N: # of overdue Service Plan 12 months renewals which were remediated within 30 days by the OA and MCO. D: Total # of OA and MCO overdue Service Plans 12 months renewals.

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

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

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

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

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

Data Aggregation and Analysis:

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

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:
36D: # and % of OA and MCO participants who received services in the type, scope, amount, duration, and frequency as specified in the service plan. N: # of OA and MCO participants reviewed who received services as specified in the service plan. D: Total # of OA and MCO participants reviewed.

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

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

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

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

collection/generation *(check each that applies):*	*(check each that applies):*	
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: EQRO /MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:
37D: # and % of OA and MCO participants records with the most recent plan of care indicating the participant had choice between wvr svcs and institutional care; and between/among svcs and providers. N:# of OA and MCO participant records reviewed with a signed POC that indicates part. had choice between wvr svcs and between svcs and providers. D:Total # of OA and MCO participant records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: HSP QA Audit Reports; QIO Reviews

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

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by

the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Medicaid agency, HFS, will conduct routine programmatic and fiscal monitoring for both the OA and the MCOs.

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

On a random basis, DRS surveys program customers on an annual basis in order to determine customer satisfaction concerning provision of waiver services. Information gathered from surveys are evaluated and considered by administration with respect to need for program modification and improvement.

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

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

The State's understanding is that the federal requirements indicate contact shall be made at least annually, and the State would appreciate clarification as to whether this requirement has changed. In the event that it has, the program could consider a system for additional contacts by OA counselors for cases where a participant has complex needs. These individuals could be contacted more or less often, up to one year, utilizing criteria such as DON score, hours on the service plan, type of provider utilized, and complexity of case. Those with the most complex needs could be contacted more frequently than those customers with fewer service needs.

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.
25D:If plans do not address required items, the OA/MA will require the plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.

26D:If plans do not address required items, the OA/MA will require the plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.

27D:If plans do not address required items, the OA/MA will require the plans be corrected and will provide training of case managers. Remediation must be completed within 60 days.

28D:If identifying information is available for individual surveys the OA and MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.

29D: The OA/MCO provides training to case managers and authorizes service plans if appropriate. Remediation must be completed within 60 days. If remediation is not completed within 60 days, the OA/MCO reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

30D:If plans are not signed by appropriate parties, the OA/MA will require the plans be corrected. The OA/MCO may also provide training in both cases. Remediation must be completed within 60 days.

31D: The OA and MCO would develop and implement PA back up plans and revisions to customers' service plans. Timeline for remediation would be within 30 days.

32D:If participants do not receive annual contact by case manager, the OA/MA will require the participant be contacted and provide training of case managers. Remediation must be completed within 60 days.

33D:If service plans are untimely, the OA/MA will require completion of overdue service plans and justification from the case manager. If service plans are not updated when there is documentation that a participant's needs changed, the OA/MCO will require an update. In both cases the OA/MCO may also provide training of case managers. Remediation within 60 days.

34D: The OA/MCO conducts timely completion of the overdue Support Plans and renewals. The OA/MCO may also provide training for case managers. Remediation must be completed within 30 days. If remediation is not completed within 30 days, the OA/MCO reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

35D:If plans do not address required items, the OA/MCO will require that the plans be corrected and provide training of case managers. Remediation must be completed within 60 days.

36D:If a participant does not receive services as specified in the service plan, the OA/MCO will determine if a correction or adjustment of service plan, services authorized, or services vouchered is needed. If not, services will be implemented as authorized. The MCO may also provide training to case managers. If the issue appears to be fraudulent, it will be reported by the OA/MA to fraud control. Remediation must be completed within 60 days.

37D:The OA/MCO will assure that choice was provided as shown by the correction of documentation to indicate customer choice. The OA/MCO may also provide training to case managers. Remediation must be completed within 60 days.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

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

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

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

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

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

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Illinois has offered consumer direction in the home services program since the early 1980s. Participant/customers may either hire their own service providers or use an agency provider. Participant/customers are encouraged to use their own service providers, whenever possible.

Most participant/customers choose to hire personal assistants (PA) for their care. PAs are individual service providers that are hired by, and are directly supervised by participant/customers. In addition, if particular PAs are not performing to participant/customer satisfaction, the participant/customer may take disciplinary action against the PA, including discharge. Participant/customers work with PAs to arrange work schedules to address services identified on the service plan, and to meet participant/customers' scheduling needs as well. Participant/customers may either directly train PAs in effectively meeting their particular services needs, or may coordinate PA training through another resource.

As the employer, participant/customers must sign timesheets to approve and verify the hours that the PA has worked. Signed timesheets are then forwarded to the DRS Home Services Program district office for further verification and payment. The operating agency has developed a payroll system to pay independent providers twice monthly. The payroll system withholds unemployment, FICA, other employee benefits and other deductions as requested by the provider.

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

Homemaker agencies are utilized when participant/customers do not have the capacity to appropriately supervise a PA, or when a PA cannot be located for the participant/customer. Homemakers are supervised by their respective homemaker agency. Again, the participant/customer may select an agency of their choice. Homemaker services are provided in accordance with the participant centered plan of care, and in accordance with provisions specified in a rate agreement with DHS. Other individual (non-agency) providers may include home health aide, licensed practical nurses, registered nurses, or therapists. Participant/customers may still opt to select their preferred provider for nursing care or therapy, however due to the clinical nature of nursing and therapies, participant/customers do not supervise services provided by these individual providers. Services are provided in accordance with appropriately designed and approved clinical plans.

Clinical services are only provided as prescribed by the physician. Although the participant/customer exercises self-direction as indicated above, the actual provision of clinical services must be provided in accordance with clinical standards and must be prescribed.

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

Payment for agency providers is authorized at the local Home Services Program office.

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning. Participant direction is the cornerstone of the ICP demonstration project. Plans allow participants, who elect to and can safely direct their own services, the opportunity and supports needed. Opportunities for participant direction, at minimum remain the same as described above. This includes that participants will actively participate in their own care plan development, including the selection of providers and services to receive or not receive, and maintain employer authority.

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

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

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

During the initial assessment, subsequent reassessments, and the service planning process, the counselors provide information to the participant/customers about participant directed services and choice of worker. Participant/customers are given a "Participant/customer Packet", which includes: a Personal Assistant Packet; guidelines for self-directed care; Rights and Responsibilities brochure which during WY 1 will be reviewed and language added to comport with Medicaid rules related to Participant Centered Planning and HCBS settings; a Participant Bill of Rights which will also be added in WY 1 to reflect language that comports with Medicaid rules related to Participant Centered Planning and HCBS settings; the right to appeal; informal resolution, and information about the Client Assistant Program (CAP); Employment Agreement; Optional Criminal Background Check form; and a Medicaid provider agreement.

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

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

If an individual elects to change from an agency to a personal assistant, the counselor sends a Payment Request form to the agency to terminate services. This form outlines the services and the termination date. The participant/customer then selects the PA and the documents in the PA packet are completed.

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning. The Plan care coordinator is responsible for furnishing the information as part of the service planning process to inform decision-making concerning participant direction. The content of the information at minimum remains the same as described above.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A participant/customer is considered anyone who: 1) has been referred to HSP for a determination of eligibility for services; 2) has applied for services through HSP; 3) is receiving services through HSP; or 4) has received services through HSP.

If the participant/customer is unable to satisfy any of his/her obligations under the HSP, including, without limitation, the obligation to serve as the employer of the PA, the participant/customer's parent, family member, guardian, or duly authorized representative may act on behalf of the participant/customer and is included within the definition of " participant/customer", as used throughout this Part.

A legally responsible family member is a spouse, parent of a child who is under age 18 or a legal guardian of an individual who is under age 18. Waiver services may be directed by a legally responsible family member of a participant/customer.

Non-legal representatives will only participate in the assessment process when so designated by the participant/customer, and also will only participate in the decision-making process when approved by the participant/customer. The participant/customer is encouraged to have significant others and members of his/her circle of support.

Safeguards are in place to protect the participant/customer when non-legal representatives are involved. These safeguards are described below:

Counselors meet with participant/customers at least annually. Participant/customers are provided with an information folder which includes information about their case, their appeal rights, and DHS contact information. Additional brochures have been described previously. Participant/customers are advised to contact the HSP office if their situation changes, any time there is a problem, or if there is a change in need for service.

HSP staff are mandated reporters of abuse, neglect, and financial exploitation. When there are allegations of abuse and/or neglect or if suspected by HSP, Adult Protective Services is notified. If HSP believes that the participant/participant/customer is in immediate danger, the local police are notified. In cases of

suspected abuse by a service provider, that provider is removed from service, and a new provider is assigned to the participant/participant/customer.

Participants are invited to participate in all aspects of their assessment and service planning process to the best of their ability to understand and contribute to the process. Legally responsible parties or legal representatives may be part of the assessment and service planning process. Participants who do not have a legal representative are offered to invite a representative to each assessment and reassessment visit to support or assist them during the assessment and service planning process. The participant may also wish to have a non-legal representatives assist them in decision making or navigating the waiver and health plan services.

If the participant is able to direct their care, then non-legal representatives will participate in the assessment, service planning, and decision-making process only when approved by the participant.

Participants who are not able to direct their own care may have non-legal representatives support and assist in the assessment and service planning process if they are acting in the best interest of the participant. Safeguards in place to ensure non-legal representatives act in the best interest of the participant include the quarterly assessment by the Plan's case manager to confirm members needs are being met according to the service plan, informal supports are being provided as previously identified in the assessment, other contacts done by the case manager to ensure service implementation and well-being for a participant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Respite	☑	☐
Physical Therapy	☑	☐
Home Health Aide	☑	☐
In-Home Shift Nursing	☑	☐
Speech Therapy	☑	☐
Intermittent Nursing	☑	☐
Occupational Therapy	☑	☐
Individual Provider (Personal Assistant - Non Agency)	☑	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☑ **Governmental entities**

☐ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. **Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

FMS are provided by DRS in accordance with standard accounting and auditing procedures. DRS administers FMS that are aligned with fiscal management procedures that are utilized by the HFS Medicaid program. This includes quality assurance procedures to verify services are provided and paid in accordance with policy, rules, and regulations.

Illinois does not procure an FMS as it is performed by a state agency, the Illinois Department of Human Services (DHS). The DHS Division of Rehabilitation (DHS-DRS) operates a payroll system for independent providers that are consumer directed. The Internal Revenue Services recognizes the customer and the DHS-DRS as the co-employer of record. The customers must sign service calendars to verify the hours worked. The independent (non-agency) provider sends the hours worked to the Home Services Program local office for review and approval. The local HSP office then enters the payment into the WebCM System that includes internal edits to assure that the correct rates and the claims are within the service cost maximum. The DHS state operated payroll system pays independent providers twice monthly. The payroll system withholds unemployment, FICA, union dues and other deductions as requested by the providers. All worker's compensation claims come through the DHS-DRS and are processed by the Illinois Department of Central Management Services, Risk Management. The DHS-DRS case management system provides guidance and oversight of customers hiring independent providers. The Client Assistance Program provides advocacy and guidance to customers.

ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

No external agencies are utilizied for FMS. This is a function of the operating agency.

iii. **Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☑ **Assist participant in verifying support worker citizenship status**

☑ **Collect and process timesheets of support workers**

☑ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☐ **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- ☐ **Maintain a separate account for each participant's participant-directed budget**
- ☐ **Track and report participant funds, disbursements and the balance of participant funds**
- ☐ **Process and pay invoices for goods and services approved in the service plan**
- ☐ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☐ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☐ **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The FMS is part of the State of Illinois. Monitoring occurs as a routine function of the fiscal oversight processes in both the operating agency and the Medicaid agency.

HFS, as the Medicaid single State agency, receives and reviews the DHS quarterly administrative claim that includes administrative expenditures of DRS. Each quarter, the entire claim is reviewed for variances from prior quarters. For instance of variances, HFS requests and reviews a detailed expenditure documentation to assure that the costs are adequately supported. Any discrepancies are corrected in the next quarterly claim.

In addition, as referenced in Section I-1 (b) of the waiver applicants, HFS conducts post claim reviews of waiver claims and reviews rates from the perspective of correct rate applied for a specific waiver service.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Participant/customers are informed of the type of availability of services offered through the Persons with Disabilities waiver. Additionally, participant/customers have the right to choose their service providers and which HSP approved vendor will provide them with goods or services (Section 677.40 Freedom of Choice). At initial eligibility determination, participant/customers are informed of the variety of services available through the "Participant/customer Guidance on Rights/Responsibilities/Appeal Procedures (HSP-1)" and are offered this information at subsequent reassessments as well. This document provides detailed information on waiver services, and is explained to the participant/customer during assessments.

HSP Counselors are responsible for providing information and support to participant/customers. Participant/customer rights and responsibilities are explained to the participant/customers, as well as the purpose and scope of the program, and information concerning the types of available services.

Participant/customers using Individual Provider services are required to collect and certify certain information for each Individual Provider used. If the participant/customer does not complete and submit the Individual Provider Standards form (IL 488-2112, revised 12/13) before the Individual Provider begins employment; it may result in non-payment to the Individual Provider and ineligibility for further services for the participant/customer.

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning. The Plan care coordinator is responsible for providing the information and assistance in support of participant direction.

Participant/customers are informed about their right of self-direction during the initial eligibility assessment and subsequent reassessments. This is reviewed with the participant/customer through a variety of methods:
• Participant/customer choice and right of self-direction is reviewed on the “Application and Redetermination of Eligibility Agreement.”
• Recommendations, evidence of training, and physician approval to complete incidental health care tasks are identified on the “Individual Provider Standards” form.
• Review of the personal assistant’s performance and participant/customer satisfaction are reviewed on the “Personal Assistant Evaluation” form.

All of this information is discussed with the participant/customer, and the participant/customer signs the forms to indicate that the information has been reviewed. Additionally, participant/customers are offered the opportunity to complete background checks on personal assistants. MCO participants are also provided the “Points to Ponder” document to assist in making decisions on self-directed services. All participants (MCO and FFS), are required to complete personal assistant evaluations. The MCO and the OA are responsible for assuring the evaluations are completed and for handling any issues of concern.

The Client Assistance Program also known as the CAP program is available to all participants (both FFS and MCO).

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Homemaker	☐
Respite	☑
Physical Therapy	☑
Home Health Aide	☑
In-Home Shift Nursing	☑

Adult Day Care	☐
Speech Therapy	☑
Home Delivered Meals	☐
Specialized Medical Equipment	☐
Intermittent Nursing	☑
Environmental Accessibility Adaptations	☐
Personal Emergency Response System	☐
Occupational Therapy	☑
Individual Provider (Personal Assistant - Non Agency)	☑

☑ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

There are two primary entities that furnish supports to consumers regarding participant direction, the HSP counselors and the Centers for Independent Living (CIL). DRS administration also provides ongoing support and consultation to the HSP counselors in order to facilitate their support of participant direction.

The CILs are located throughout the state and provide training for consumers on how to manage their personal assistants.

At each reassessment, the HSP counselor discusses the rights and responsibilities related to having a personal assistant. Each consumer receives a document titled "Points to Ponder", that discusses the issues of hiring family members as caregivers.

The DRS Quality Assurance unit and HFS conduct annual reviews of consumer records. DRS and HFS meet quarterly to discuss monitoring findings and overall quality management issues. Issues identified through monitoring are discussed and addressed both individually and systemically.

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning. The Plan care coordinator is responsible for providing the information and assistance in support of participant direction. The MA monitors the performance through analysis of reports, onsite monitoring, desk audits and interviews for those waiver participants enrolled in an MCO. Participants in MCOs are included in the representative sampling.

There are no differences between the MCO and FFS in the monitoring of enrollees who self-direct services. These enrollees have an equal opportunity of being selected in the representative sample.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Illinois offers an independent entity called the Client Assistance Program (CAP). This program helps people with disabilities receive quality services by advocating for their interests and helping them identify resources, understand procedures, resolve problems, and protect their rights in the rehabilitation process, employment, and home services. CAP provides services through advocates and attorneys located throughout Illinois. All CAP services are free and confidential.

CAP services include:

-Assisting individuals with problems they experience in seeking or receiving services.

-Trying to resolve issues at the lowest possible level (such as the local office), using advocacy skills, dispute resolution, and negotiation.

-Assisting or representing individuals in their appeals of decisions regarding services and, if necessary, represent them in court.

-Working with the department, community groups, and advocacy organizations to resolve system problems.

-Providing public education programs on the rights of individuals with disabilities and other related issues.

-Providing information and referral to related services.

DRS provides each participant/customer with a copy of the Home Services Program Appeal Fact Sheet (HSP I) initially, at each reassessment and upon request. The HSP I includes information on the right to appeal. In addition, the document includes information about the Client Assistance Program (CAP). CAP is a statewide program designed as an advocate program for HSP and Vocational Rehabilitation consumers.

When a complaint is presented to the CAP, the CAP representative brings the consumer's complaints to one of the three HSP zone offices. A CAP representative is assigned to each zone and is responsible for handling complaints and questions in his or her zone. The CAP representatives meet weekly to insure consistent responses.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

During the service planning process, case managers review many factors to determine if the participant/customer has the ability to self-direct. Examples of items reviewed would include medical information, psychological information, and interviews of individual and family.

If the participant/customer has the capacity to self-direct and chooses a personal assistant, the service plan is developed and the participant/customer is provided information about becoming an employer of the personal assistant.

If the participant/customer does not have the capacity to self-direct, he or she may choose a family or guardian to manage the personal assistant or choose an agency-based provider.

If a participant/customer chooses to self-direct and there are problems with the personal assistant such as fraud or abuse by participant/customer; or situations where the participant/customer's physical or mental health regresses, the case manager will work with the participant/customer to find an agency provider. Like any change in the service plan, this may be appealed. Until the appeal is settled, the same level of services is provided until the appeal is settled. When transitioning from self-directed to agency-based services, the case manger assures that there is no break

between services.

The Centers for Independent Living (CIL), in conjunction with the Home Services Program provides training to assist participant/customers in the management of Personal Assistants. When a participant/customer goes from self-directing services to receiving agency-based services and wants to go back to self-direction, HSP suggests that the participant/customer participate in the training.

When a participant/customer is in between personal assistants, DRS immediately increases the service plan and contacts a homemaker agency to maintain continuity of care as the participant/customer finds a new personal assistant.

For participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning and implementation monitoring. The Plan care coordinator is responsible for providing needed supports for participant direction. The Plan coordinator will assist the participant to choose alternate services and ensure supports are in place for continuity of care, health and welfare during the transition.

All enrolled waiver participants will be offered the opportunity to direct none, some, or all of their services. A waiver participant who selects to direct none or some of their services can obtain their waiver services through provider-managed services.

All waiver participants who select to direct their services can at any time terminate that choice and transition to agency-based services. In order to assure the participant's health and safety and no interruption in services the Plan will coordinate the transition from self-direction to provider-managed services to assure no break in services.

Voluntary terminations will be recorded on the participant's service plan and will be indicated by the participant's approval of the new service plan. Services provided by a personal assistant will only be provided when it has been determined by the HSP counselor that the customer has the ability to supervise the personal care provider. In cases where the counselor determines that: the personal assistant cannot meet the needs in the care plan, the customer cannot manage a personal assistant, or the customer's health or safety is at risk; the counselor will acquire homemaker services through an agency provider. These services will be provided in accordance with the plan of care.

For participants enrolled in an MCO, the Plan care coordinator will provide the necessary supports to assure continuity of services and participant health and welfare during the transition.

Services provided by a personal assistant will only be provided when it has been determined by the Plan's case manager that the participant has the ability to supervise the personal care provider.

In cases where the Plan's case manager determines that the personal assistant cannot meet the needs of the member outlined in the service plan, or the participant cannot manage a personal assistant (and if the participant has no reliable person available to assist in managing the personal assistant), or the participant's health or safety is at risk by continuing to use a personal assistant, the Plan case manager will consider the need to terminate the participate directed service involuntarily.

Prior to terminating any participant directed service the Plan case manager will send the participant a Notice of Action that provides the member with information as to why their service is being terminated or reduced and includes their rights to appeal and fair hearing process.

The Plan case manager will replace the participant directed service with comparable agency directed services and do so timely to prevent a gap in service or care. Participants maintain the right to choose an agency provider in the Plan's contracted provider network. The service plan will be updated to reflect any changes.

The OA and MCOs use a standard process for determining the participant/customer's ability to self-direct. If the customer is unable to communicate or has cognitive or emotional limitations that negatively impact their communication or decision-making ability, the case manager may determine that the customer does not have the capacity to self-direct their services. This determination is typically supported from case documentation, which can be obtained from a number of sources, including but not limited to: medical reports, psychological and neuropsychological evaluations, case manager observations, documented instances showing the inability to properly manage a personal assistant, information from the customer's family and/or representative, and failure to pass the Mini-Mental Status Examination on the DON. If it is determined that a customer cannot self-direct, the case manager will identify a legal guardian, power of attorney, or other individual to represent the customer and to assist with the

assessment and service planning process.

The MCOs have received initial and ongoing training from the OA regarding participant direction and oversight of personal assistants. The OA has shared their provider standards with the MCOs that include information on how to determine if the PA can meet the customer's needs. The OA also provides guidance on how to determine when a PA is not meeting needs and when it is appropriate to change from a PA to a homemaker provider. The MA and OA do not specifically monitor the decisions that are made by the MCO.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Services provided by a personal assistant will only be provided when it has been determined by the HSP counselor that the customer has the ability to supervise the personal care provider. In cases where the counselor determines that: the personal assistant cannot meet the needs in the care plan, the customer cannot manage a personal assistant, or the customer's health or safety is at risk; the counselor will acquire homemaker services through an agency provider. These services will be provided in accordance with the plan of care.

For participants enrolled in an MCO, the Plan care coordinator will provide the necessary supports to assure continuity of services and participant health and welfare during the transition.

Services provided by a personal assistant will only be provided when it has been determined by the Plan's case manager that the participant has the ability to supervise the personal care provider.

In cases where the Plan's case manager determines that the personal assistant cannot meet the needs of the member outlined in the service plan, or the participant cannot manage a personal assistant (and if the participant has no reliable person available to assist in managing the personal assistant), or the participant's health or safety is at risk by continuing to use a personal assistant, the Plan case manager will consider the need to terminate the participate directed service involuntarily.

Prior to terminating any participant directed service the Plan case manager will send the participant a Notice of Action that provides the member with information as to why their service is being terminated or reduced and includes their rights to appeal and fair hearing process.

The Plan case manager will replace the participant directed service with comparable agency-based services and do so timely to prevent a gap in service or care. Participants maintain the right to choose an agency provider in the Plan's contracted provider network. The participant centered service plan will be updated to reflect any changes.

The OA and MCOs use a standard process for determining the customer's ability to self-direct. If the customer is unable to communicate or has cognitive or emotional limitations that negatively impact their communication or decision-making ability, the case manager may determine that the customer does not have the capacity to self-direct their services. This determination is typically supported from case documentation, which can be obtained from a number of sources, including but not limited to: medical reports, psychological and neuropsychological evaluations, case manager observations, documented instances showing the inability to properly manage a personal assistant, information from the participant/customer's family and/or representative, and failure to pass the Mini-Mental Status Examination on the DON. If it is determined that a participant/customer cannot self-direct, the case manager will identify a legal guardian, power of attorney, or other individual to represent the customer and to assist with the assessment and service planning process.

The MCOs have received initial and ongoing training from the OA regarding participant direction and oversight of personal assistants. The OA has shared their provider standards with the MCOs that include information on how to determine if the PA can meet the participant/customer's needs. The OA also provides guidance on how to determine when a PA is not meeting needs and when it is appropriate to change from a PA to a homemaker provider. The MA and OA do not specifically monitor the decisions that are made by the MCO.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	24424	
Year 2	25890	
Year 3	27443	
Year 4	29090	
Year 5	30571	

Appendix E: Participant Direction of Services

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

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

- [x] **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

  Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

  The co-employer is the State of Illinois, Division of Rehabilitation Services.
- [ ] **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- [x] **Recruit staff**
- [ ] **Refer staff to agency for hiring (co-employer)**
- [ ] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [x] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

If a participant/customer requests that a criminal background check must be completed, DRS obtains the criminal background check on behalf of the customer and pays all costs associated with acquiring the background check.

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [ ] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the State's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

iv. Participant Exercise of Budget Flexibility. *Select one*:

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

Eligible individuals (or their parent or legal guardian) will be informed of the feasible alternatives available under the waiver at the time they make application for waiver services. The Choice form is explained to the individual and alternative providers in the area presented in order for the individual to make an informed choice between waiver and institutional services. Individuals may consider other potential providers with visits arranged by the OA Counselor before they choose services.

The fair hearing process is explained to the individual or legal guardian at the time of initial application, upon redetermination for the program, and upon any change in services with which the client does not agree. Rules for fair hearings are found at 89 Il. Adm. Code, Part 510, Appeals and Hearings, and are summarized throughout this section. The Medicaid agency is the final level of appeal.

Notice will be provided to the participant/customer by the OA Counselor for each of the following adverse actions. HSP services shall be denied or terminated and case closure initiated at any time the participant/customer:

-Refuses services or further services;
-Moves from the State of Illinois or cannot be located or contacted;
-Dies;
-Is institutionalized and not expected to be released for a period to exceed 60 calendar days;
-Is determined to have a projected service cost above that of the projected cost of institutionalization, with the exceptions found at 89 Il. Adm. Code 682.500(a), 682.520, and 684.70(c);
-Has been referred to another agency for the same or similar services and no longer requires or is eligible for HSP services;
-Fails to conduct himself/herself in an appropriate manner (e.g., physical, sexual or repeated verbal abuse by a participant/customer against a DHS employee, provider or agent providing services through the OA; knowingly providers false information; or performs illegal activity that would directly and adversely affect the HSP);
-Is not, or is no longer, at risk of institutionalization due to improvement of his/her condition;
-Fails to meet other eligibility criteria as found at 89 Il. Adm. Code 682 as a result of an initial determination of eligibility or re-determination of eligibility.
-Fails to cooperate (e.g., refuses to complete and sign necessary forms, fails to keep appointments, fails to maintain adequate

providers) or
-Cannot have a safe and adequate service plan developed for him/her as a result of the original determination of eligibility or redetermination of eligibility
When an OA counselor makes an adverse case decision, the participant/customer will receive a service notice that explains the decision and informs the participant/customer of his/her right to appeal. The service notice is sent to the participant/customer at least 15 days prior to the effective date of the action. The counselor is responsible to notify the participant/customer immediately after the decision. If the participant/customer desires assistance during the hearing, he/she may request such assistance from the DHS Client Assistance Program (CAP). Personnel within the CAP program are impartial advocates who assist the participant/customer during the appeal process. The service notice indicates that services will continue until after the hearing office renders a decision. A copy of the service notice is retained in the case file. When available, a copy of the request for appeal may also be in the service file, and will always be maintained in the appeal file under the DHS Division of Hearings and Appeals.

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

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

MCOs inform Enrollees about the Medicaid agency's fair hearing process in the member handbook distributed at the time of enrollment. Information about the fair hearing process is also on the MCOs website on an ongoing basis and is provided whenever an Enrollee requests the information. An Enrollee may appoint a guardian, caretaker relative, Primary Care Provider, Women's Health Care Provider, or other Physician treating the Enrollee to represent the Enrollee throughout the Appeal process.

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

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

Each MCO submits a monthly Grievances and Appeals detail report and a quarterly Grievance and Appeals summary report to the MA. The format of each report is dictated by the MA. The monthly reports provide a record of appeals requests in detail, including a description of each Grievance and Appeal, outcome, incident summary, resolution summary, and dates. The quarterly summary report of Grievances and Appeals filed by enrollees is organized by categories of medical necessity reviews, access to care, quality of care, transportation, pharmacy, LTSS services and other issues. It includes the total grievance and appeals per 1,000 Enrollees for their entire MMAI population. Additionally, it includes a summary count of any such Appeals received during the reporting period including those that go through fair hearings and external independent reviews. Finally, these reports include Appeals outcomes- whether the appeals were upheld or overturned. Appeals are reported separately for each Waiver. HFS reviews and analyzes the grievance and appeals reports. HFS compares the reports among plans over time and across plans to analyze trends, outliers among plans and to assure that the plans are addressing areas of concern. Records of adverse actions and requests for appeals are maintained by the MCOs for a period of six (6) years.

1) The State ensures that managed care enrollees are informed by the MCO about their Fair Hearing Process by reviewing and prior approving the Enrollee Handbook, Notice of Action, and any appeal letters which must contain the enrollees' rights to a Fair Hearing and how to request such. The States EQRO also reviews such documents through a desk review and determines if the MCO is compliant during on-site visits. The State reviews/approves the MCO's appeal process guidelines.

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

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

The Notice of Action also contains information on appealing the determination and how services can continue during the period while the participant's appeal is under consideration.

The Plans have a separate appeal process that occurs prior to the Fair Hearing process. If an appeal is upheld by the Plan, the Plan sends an Appeal decision letter. This letter contains instructions/information on the Fair Hearing process.

Copies of the Notice of Action documents, including notices of adverse actions and the opportunity to request a Fair Hearing, are maintained by the Plan in a database.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

   - ○ **No. This Appendix does not apply**
   - ◉ **Yes. The State operates an additional dispute resolution process**

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

   Prior to scheduling a hearing, the participant/customer may be offered the opportunity to participate in an informal resolution conference. The primary goal of this exercise is to attempt to reach mutual resolution of the issues being appealed. Participant/customers may request an Informal Resolution Conference, in the period between the filing of the appeal and the hearing decision, by contacting the office out of which they receive services. (Customer's Guidance on Rights/Responsibilities/Appeals Procedures; Section 510.100 Informal Resolution Conference.)

   "Informal resolution" offers an opportunity to resolve differences prior to going to hearing. This may take the place of the hearing, if all parties agree on the resolution, but is not required. This is offered as another mechanism through which to address customer's concerns. If the issue cannot be resolved, then the case proceeds to the hearing level. Informal resolution is conducted by DRS central office staff, and includes the HSP Counselor and customer, and other individuals, as required although ordinarily this is kept as informal as possible. If the issues under appeal are resolved according to the satisfaction of all parties, the customer's services will reflect this, the customer will withdraw the appeal, and the DHS Division of Hearings Administration will close the appeal file.

   DHS Division of Hearings and Appeals utilizes impartial hearing officers who work with HSP to schedule hearings. The hearings are scheduled according to availability of all parties. At least three days prior to the hearing, information submitted by each participant is forwarded to all parties. The hearing officer conducts the hearing, and afterwards renders a decision within 90 days following the hearing. The final administrative decision is made by the Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

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

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

The Department of Human Services, Division of Rehabilitation Services is responsible for operating the grievance/complaint system. This system is discussed in section F-1: Opportunity to Request a Fair Hearing.

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

Each MCO is required to establish and maintain a procedure for reviewing grievances (any expression of dissatisfaction about any matter other than an action) registered by Enrollees. All Grievances are registered initially with the MCO and may later be appealed to the Department through the Fair Hearing process. Enrollees must exhaust the MCO's Grievance process before requesting a Fair Hearing.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) DRS administration is responsible for ensuring that all Unusual Incident Reports (UIR) are processed in a timely and appropriate manner. Immediately upon receipt of an unusual incident report, it is shared with the designated unit within DRS that is responsible for coordinating these investigations. UIR Unit staff determine whether the incident includes abuse, neglect, or financial exploitation, and if so, the Adult Protective Services is immediately contacted. Additionally, it is determined whether immediate agency action is required. If so, the HSP counselor is provided with specific instructions on any actions to pursue. Any direction received from Adult Protective Services is also acted on immediately. Throughout this process, UIR Unit staff work directly with DRS central office staff as well as the local HSP counselor in order to ensure proper resolution. As a result, a high level of interaction is maintained on an ongoing basis by administrative and field staff.

(b) DRS administration maintains and monitors an unusual incidents database on an ongoing basis. Data is reviewed for analysis, and to determine if there are any trends or issues requiring further investigation. Results of this review will be shared with HFS administration at least annually. Any trends and/or patterns determined from data analysis will be addressed by DRS and HFS as needed or during quality management meetings. Upon receipt of a grievance or complaint, the HSP counselor immediately completes an unusual incident report that is disseminated to appropriate DHS administrative personnel. Again, if the issue concerns possible abuse and neglect, Adult Protective Services is notified as well.

(c) The participant is informed that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing. Fair hearings result from appeals filed by the customer for adverse decisions that have been rendered by the HSP counselor. For instances in which the counselor is accused of misconduct, then an unusual incident (complaint) report would be filed and the customer would also have the option of filing an appeal if the conduct resulted in an adverse case decision.

For participants enrolled in an MCO, all grievances shall be registered initially with the Plan and may later be appealed to the MA. The Plan's procedures must: (i) be submitted to the MA in writing and approved in writing by the MA;(ii) provide for prompt resolution, and (iii) assure the participation of individuals with authority to require corrective action. The Plan must have a Grievance Committee for reviewing grievances registered by its enrollees, and enrollees must be represented on the Grievance Committee. At a minimum, the following elements must be included in the Grievance process:

- •An informal system, available internally, to attempt to resolve all grievances;
- •A formally structured Grievance system that is compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 C.F.R. Part 438 Subpart F to handle all Grievances subject to the provisions of such sections of the Act and regulations (including, without limitation, procedures to ensure expedited decision making when an Enrollee's health so necessitates);
- •A formally structured Grievance Committee that is available for Enrollees whose Grievances cannot be handled informally and are not appropriate for the procedures set up under the Managed Care Reform and Patient Rights Act. All Enrollees must be informed that such a process exists. Grievances at this stage must be in writing and sent to the Grievance Committee for review;
- •The Grievance Committee must have at least one (1) enrollee on the Committee. The MA may require that one (1) member of the Grievance Committee be a representative of the MA;
- •Final decisions under the Managed Care Reform and Patient Rights Act procedures and those of the Grievance Committee may be appealed by the enrollee to the MA under its Fair Hearings system;
- •A summary of all Grievances heard by the Grievance Committee and by independent external reviewers and the responses and disposition of those matters must be submitted to the MA quarterly; and
- •An enrollee may appoint a guardian, caretaker relative, PCP, WHCP, or other Physician treating the enrollee to represent the Enrollee throughout the Grievance process.

The state has provided that individuals must first avail themselves of the internal grievance and appeals process before accessing the Fair Hearings process. Enrollees are notified of this through the Enrollee Handbook, the Notice of Action, and any appeal letters. Plans also discuss the grievance and appeals process with the Enrollee during the service planning process.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

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

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

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

Participants under the age of eighteen:

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 a specific set of circumstances involving suspected abuse or neglect, where there is demonstrated harm to the child or a substantial risk of physical or sexual injury to the child. Critical incidents must be reported if the alleged perpetrator is a parent, guardian, foster parent, relative caregiver, paramour, any individual residing in the same home, any person responsible for the child's welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust (for example: health care professionals, educational personnel, recreational supervisors, members of the clergy, volunteers or support personnel) in settings where children may be subject to abuse and neglect.

Although anyone may make a report, mandated reporters are professionals who may work with children in the course of their professional duties. There are seven groups of mandated reporters defined in the Abused and Neglected Child Reporting Act ANCRA (325 ILCS 5/4). They include: medical personnel, school personnel, social service/mental health personnel (including staff of both the Waiver Medicaid Agency and the Waiver Operating Agency), law enforcement personnel, coroner/medical examiner personnel, child care personnel (including all staff at overnight, day care, pre-school or nursery school facilities, recreational program personnel, foster parents), and members of the clergy.

Mandated reporters are required to report suspected child maltreatment immediately when they have reasonable cause to believe that a child known to them in their professional or official capacity may be an abused or neglected child. This is done by calling the Department of Children and Family Services 24-hour hotline (800-25-ABUSE). Reports must be confirmed in writing to the local investigation unit within 48 hours of the hotline call.

DCFS Hotline Numbers:
1-800-25-ABUSE or 1-800-252-2873 (voice)
1-800-358-5117 (TTY)

Participants aged 18 through 59:

Adult Protective Services

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

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

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

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

Abuse means physical, sexual or emotional maltreatment or willful confinement.

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

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

Reporting

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

Mandated Reporters

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

Reporting Timelines

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

Other Incidents Other Critical Incidents including those resulting in Death or Injury not related to ANE

If HSP counselors are made aware of the incidents, they are reported to the DRS central office and an HSP Counselor is assigned to the case. HSP counselors assist with reporting and remain involved in the case to ensure the customer is safe from harm and that an adequate plan of care is in place.

DRS central office enters information into a database for abuse, neglect, incidents, and complaints. DRS works with each case until there is satisfactory resolution.

Reports may be generated by DRS that can be tailored to meet specific data needs. Information gathered on the database includes customer demographic data, alleged perpetrator information, incidents of alleged or substantiated abuse and neglect, involvement from the Office of Inspector General or the Department on Aging, action taken by DRS, and outcome information. These reports are shared on a quarterly basis with HFS.

For participants enrolled in an MCO, the Plans will have processes and procedures in place to receive reports of critical incidents. The Plans shall comply with the Department of Human Services Act (20 ILCS 1305/1-17), the Adults with Disabilities Domestic Abuse Intervention Act (20 ILCS 2435), and the Abused and Neglected Child Reporting Act (325 ILCS 5/4). The Plan shall have a formal process for reporting incidents that may indicate abuse, neglect or exploitation of an Enrollee.

The Plans must comply with the Operating Agency's critical incident reporting requirements. At a minimum abuse, neglect and exploitation must be reported. Other examples of critical events may include but are not limited to:
• Death
• Suspicious death
• Falls
• Serious physical injury
• Hospital admission
• Misuse of funds
• Medication error
• Unauthorized use of restraint, seclusion or restrictive physical or chemical restraints
• Elopement or missing person

• Fires
• Severe natural disaster
• Possession of firearms (participant or staff)
• Possession of illegal substances (participant or staff)
• Criminal victimization
• Financial exploitation
• Suicide or attempted suicide

For these types of incidents, if there is a perceived immediate threat to a member's life or safety, the Plan will follow emergency procedures which may include calling 911.

All incidents will be reported to the compliance officer or designee and entered in to the Plans Critical Incidents report database. Based on situation, the members age and placement reports will also be made to the appropriate State of Illinois investigative agencies.

The Plans will continue to provide the participants, their family or representatives information about their rights and protections, including how they can safely report an event and receive the necessary intervention or support.

Also, the Plans will assure that HCBS waiver agencies, vendors and workers (including case managers) are well informed of their responsibilities to identify and report all critical incidents. Responsibilities are also reinforced through periodic training.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Upon initial eligibility determination, and subsequent re-determination of eligibility, participant/customers are informed of their rights and responsiblities, including their right to be free from abuse, neglect, and exploitation. Information is shared on whom to notify if abuse, neglect or exploitation occures. All waiver participants must review and sign the Home Services Program Application and Redetermination of Eligibility Agreement. The contents of this document are thoroughly explained to the customer.

As indicated above, customers have discussions about abuse, neglect, and exploitation with the OA counseling staff at initial enrollment and annual redetermination.

Training specific to abuse, neglect and exploitation is not provided, but the OA does educate participants on those topics. At the time of application and at each redetermination of eligibility, OA Rehabilitation Counselors inform participants of their right to be free from abuse, neglect and exploitation and whom to contact for help or to report concerning activity. All waiver participants must review and sign the Home Services Program Application and Redetermination of Eligibility Agreement which contains necessary information about reporting abuse, neglect and exploitation. The contents of this document are thoroughly explained to the customer.

For participants enrolled in an MCO, the Plan shall train all of Plan's employees, Affiliated Providers, Affiliates and subcontractors to recognize potential concerns related to Abuse and Neglect, and on their responsibility to report suspected or alleged Abuse or Neglect. The Plan's employees who, in good faith, report suspicious or alleged Abuse or Neglect shall not be subjected to any adverse Action from the Plan, its Affiliated Providers, Affiliates or subcontractors.

Providers, Enrollees and Enrollees' family members will be trained about the signs of Abuse and Neglect, what to do if they suspect Abuse or Neglect, and the Plan's responsibilities. Training sessions will be customized to the target audience. Training will include general indicators of Abuse and Neglect and the timeframe requirements for reporting suspected Abuse, Neglect and exploitation.

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

For participants under the age of 18:

The Department of Children and Family Services (DCFS) is the state agency that is responsible for conducting investigations of child maltreatment and arranging for needed services or protective plan as appropriate, for children and families where credible evidence of abuse or neglect exists. DCFS provides protective services at the request of the subjects of the report, even when the report has been unfounded.

DCFS field office staff are required to make initial contact and start the investigation of the allegation within 24 hours of the hotline report. If there is a possibility that the family may flee or if the immediate well being of the child is endangered, an investigation will start immediately.

Most investigations are conducted in 60 days unless there is just cause for a 30 day extension to make a determination whether the allegation is indicated or unfounded. Appropriate emergency services are provided while the investigation is pending. Emergency and ongoing services may include safety plans, protective plans, family support or protective custody, which places the child in substitute care.

Serious allegations such as sexual abuse, serious physical harm, or death are reported to the local law enforcement agency, the State's Attorney, and to the Child Advocacy Center, if available, as a coordinated approach to the investigation. The approach includes victim sensitive interviewing of the alleged child victim(s) and identification and prosecution for a criminal act. DCFS uses a Child Endangerment Risk Assessment Protocol (CERAP) to assess safety of the child. The interview process includes an assessment of the alleged victims immediate safety. Safety plans can include voluntary removal of the alleged perpetrator or of the alleged victim. If the family refuses to establish a safety plan to control for the threats of danger to the alleged victims, then the child is removed. DCFS staff conduct face-to-face monitoring and reassessment every five days until the child is determined to be safe in the home.

A protective plan is enforced in "out-of-home" settings, such as daycares and residential settings. The protective plan restricts accessibility of the perpetrator to the child, and it stays in place until the investigation is completed. If the investigation determines that an abuse or neglect situation is indicated, license revocation or remediation activities begin. Monitoring is conducted weekly by investigators and licensing staff until resolved.

If a finding is indicated, the perpetrator's name is placed on the DCFS State Central Register for a minimum of five years, 20 years if there was serious physical injury, and 50 years in cases of sexual penetration or death. If a finding is unfounded, the name is on the DCFS State Central Register for a minimum of 30 days up to three years depending on the seriousness of the situation.

Participants Age 18 through 59:

During year one of the waiver renewal, IDoA anticipates the implementation of a web-enabled system to receive all reports of critical incidents as part of its Event Reporting system. Providers and care coordinators will enter incidents directly into the secured website. Participants, family members and others may call the State's Senior Helpline: 1-800-252-8966 or the 24-Hour Adult Protective Services Hotline: 1-866-800-1409. APS
IDoA, the CCU and the care coordinator are notified of incidents in all cases. Depending on the nature of the incident of Abuse and Neglect and Exploitation (ANE), the participant and/or family members, and providers may be notified. The State has set criteria regarding when notifications are mandatory or are at the discretion of the care coordinator.

IDoA has established classifications for critical incidents (i.e., Priority I, II, III,) depending upon the nature and urgency of the event. This classification determines whether an investigation needs to occur in the timeframe for conducting that investigation. The definitions and time frames of these levels are located at 89 ILAC Section 270.240
Responding to Reports –
Depending on the nature and seriousness of the allegations, a trained caseworker makes a face-to-face contact with the alleged victim with the following time frames:

•Priority One – Reports of abuse or neglect where the alleged victim is reported to be in imminent danger of death or serious physical harm. The caseworker must make a face-to-face visit within 24 hours.

•Priority Two – Reports that an alleged victim is being abused, neglected, or financially exploited and the report taker has reason to believe that the health and safety consequences to the alleged victim are less serious that priority one reports. The caseworker must make a face-to-face visit within 72 hours.

•Priority Three – Reports that an alleged victim is being emotionally abused or the alleged victim's financial resources are being misused or withheld and the report taker has reason to believe that there is no immediate or serious threat of

harm to the alleged victim. The caseworker must make a face-to-face visit within 7 calendar days of the receipt of the report.

The State requires that all Priority I incidents be at least temporarily corrected within 24 hours and a permanent correction must occur within 60 days. All other events must be corrected within 60 days. The State's Office of Adult Protective Services' regulations also require certain response timelines by the ANE agency. These are located at 89 ILAC Part 270.

The Event Reporting system also tracks the status of any investigation and follow-up actions taken. The State has established criteria regarding when the CCU must conduct a review, when an on-site visit must occur, and when the change of status assessment must occur.

The state is responsible to ensure the health and welfare of the participant and may authorize additional services, such as intensive care coordination, to protect the welfare of the individual. Critical incidents may also result in a review of participant needs to determine whether a change in the service or level of service is needed.

APS Reporting

State requirements for reporting of abuse, neglect or financial exploitation of participants' age 60 years and older are as follows:

The Illinois Department on Aging (ID0A) Office of Adult Protective Services administers the Abuse, Neglect and Financial Exploitation Program (ANE), which responds to alleged abuse, neglect or financial exploitation of persons 60 years of age and older who reside in the community. The program provides investigation, intervention and follow-up services to victims. It is locally coordinated through 42 agencies designated by the Area Agencies on Aging (AAA) and IDoA. The Adult Protective Services Agencies conduct investigations and work with older adults in resolving abusive situations.

Abuse Hotline Number:

866-800-1409 (voice): available 24 hours a day, seven days a week
888-206-1327 (TTY)

State requirements for reporting of abuse, neglect or financial exploitation of participants age 60 years and older are as follows:

The Illinois Department on Aging (ID0A) Office of Elder Rights administers the Elder Abuse, Neglect and Financial Exploitation Program (ANE), which responds to alleged abuse, neglect or financial exploitation of persons 60 years of age and older who reside in the community. The program provides investigation, intervention and follow-up services to victims. It is locally coordinated through 43 agencies designated by the Area Agencies on Aging (AAA) and IDoA. The Elder Abuse Agencies conduct investigations and work with older adults in resolving abusive situations.

Elder Abuse Hotline Numbers:

866-800-1409 (voice): available 24 hours a day, seven days a week
800-544-5304 (TTY)

Senior HelpLine number, 1-800-252-8966, during regular business hours. After-hour and weekend calls are automatically transferred to the Elder Abuse Hotline number.

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

Immediately upon receipt of an unusual incident report, DRS submits to the designated UIR Unit within DRS. UIR Unit staff determine whether the incident includes abuse, neglect, or financial exploitation, and if so, the Adult Protective Services is immediately contacted. Additionally, it is determined if immediate agency action is required as well. Any direction received from Adult Protective Services is acted on immediately.

Incident Reporting is now completed electronically. Unusual Incident Reports (UIR) should be completed for

situations that are unusual in nature. These include, but are not limited to customer incidents, staff/customer related incidents, and PA/customer issues. All HSP IRs are entered on WebCM, the virtual case manager, as soon as the staff person becomes aware of an issue. Critical issues may have additional follow up by e-mail or telephone call. The purpose of the IR is to alert the chain of command, up to and including the OA Director, promptly of issues such as those listed above so his/her office can quickly alert the OA Secretary and immediate staff about issues. Reports are completed the same day of the incident. All reports are reviewed daily and distributed to the appropriate source for follow up. Follow up may be on the specific incident only or may require alerts or directions to all staff for program wide changes aimed at preventing re-occurrence. As statutorily mandated reporters, HSP staff are also required to refer all incidents regarding abuse, neglect and/or financial exploitation to the statewide 24-hour Adult Protective Services Hotline. This replaces the OA's OIG. HSP will follow up with the field on all reports which deal with abuse, neglect or financial exploitation." If an incident involves someone under the age of 18, the Department of Children and Family Services is contacted.

In addition, UIR Unit staff work with the local HSP office staff to ensure proper resolution. Unusual incidents are monitored by DRS administration on an ongoing basis. Data is reviewed for analysis and to determine if there are any trends or issues requiring further investigation.

The Adult Protective Service Unit (APS) shall initiate an assessment of all reports of alleged or suspected abuse or neglect within 7 calendar days after the report. Reports of exploitation shall be assessed within 30 calendar days after the report is received. Reports of abuse or neglect that indicate that the life or safety of an adult with disabilities is in imminent danger shall be assessed within 24 hours after the receipt of the report. When the APS determines that a case is substantiated, it shall refer the case to the appropriate office within the Department of Human Services or the MCO to develop, with the consent of and in consultation with the adult with disabilities, a service plan to address the persons needs.

The DHS Abuse, Neglect, and Financial Exploitation (DHS-ANE) investigator contacts appropriate field personnel to request follow up on an allegation, and request an update on attempts to resolve the situation. Field personnel indicate whether or not an internal investigative review has been completed and the results of that review; and/or if external agencies were contacted for assistance such as the Office of Inspector General, the local police, the DHS Divisions of Mental Health or Developmental Disabilities, etc. All information gathered from these sources is entered into the DHS incident investigation file.

All information is gathered and stored in the customer's case file, including written, faxed, e-mailed information, case notes, etc. In addition, unusual incident reports as submitted by the field and intake and final reports from the APS are entered into the DHS-DRS unusual incident database. This information is confidential, and is retained for monitoring purposes. The data is reviewed to determine if there are trends or patterns, and if there are situations that need additional investigation or follow up. When warranted, further investigation is pursued. Information stored in the database helps to prevent recurrence of incidents involving the same customer and an alleged offender.

Additionally, the database is used as a reference for investigation of grievances, unemployment claims, and fraud allegations. Together field personnel, administration, APS, and the Unusual Incident unit work together to resolve and prevent the incidence of abuse, neglect, and financial exploitation. These activities are completed on an ongoing basis, and investigation is not complete until resolved by the APS.

For participants enrolled in an MCO, the Plans will maintain an internal reporting system for tracking the reporting and response to critical incidents. Critical incident reporting will be included in the reporting requirements to the MA. The MA monitors both compliance of performance measures and timeliness of remediation for those waiver participants enrolled in an MCO. Participants in MCOs are included in the representative sampling.

Appendix G: Participant Safeguards

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

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

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

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

The State does not authorize the use of restraint or seclusion in the waiver program. Any allegations of restraint, seclusion, or other potential abuse, neglect, or financial exploitation would be reported to OA administration via the unusual incident report procedure. Simultateously, an alleged incident would be reported to the proper authority for review.

For participants enrolled in an MCO, the Plans are responsible to detect the unauthorized use of restraint or seclusion. Events involving the use of restraint or seclusion would be reported to the Plan as a reportable incident, and reported to the investigating authority as indicated.

(See Appendix G-1 for information about critical event or incident reporting requirements.)

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

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

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

b. Use of Restrictive Interventions. *(Select one)*:

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

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

The State does not authorize the use of restrictive interventions in the waiver program. Any allegations of restrictive interventions or potential abuse, neglect, or financial exploitation would be reported to the OA administration via the Unusual Incident Report procedures. Simultaneously, an alleged incident would be reported to the proper authority for review: the Department of Children and Family Services or the Adult Protective Service Unit of the Illinois Department on Aging.

For participants enrolled in an MCO, the Plans are responsible to detect the unauthorized use of restrictive interventions. Events involving the use of restrictive interventions would be reported to the Plan as a reportable incident, and reported to the investigating authority as indicated.

(See Appendix G-1 for information about critical event or incident reporting requirements.)

The MCOs and OA will detect unauthorized use of restraints and/or seclusion through face-to-face visits, routine contacts with the participants, and possibly through complaint or incident reporting. The case managers will be responsible for the overseeing the waiver participants and assuring their health, safety, and welfare.

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

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

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

Appendix G: Participant Safeguards

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

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

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

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

Care coordinators through their regular contact monitor for all activities that appear to fall under abuse, neglect and exploitation. Seclusion would fall under this category. In addition, all providers are trained to monitor similar activities. Reports of abuse, neglect and exploitation, including seclusion are to be made to the Adult Protective Services Unit for investigation.

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

i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed

living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- (●) **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ( ) **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

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

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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

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

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

iii. Medication Error Reporting. *Select one of the following:*

- ( ) **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

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

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

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

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

Performance Measures

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

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

Performance Measure:
39G: # and % of participants' DHS-OIG substantiated incidents that were reported to the OA and MCO and resolved within recommended OIG timelines. N: # of DHS-OIG substantiated incidents reported to the OA and MCO that were resolved within recommended OIG timelines. D: Total # of DHS-OIG substantiated incidents reported to the OA and MCO.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: OIG Report (via unusual incident data base)

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

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

Data Aggregation and Analysis:

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

Performance Measure:
40G: # and % of participants' substantiated cases of A/N/E received from IDoA-APS where OA and MCO implemented APS recommendations w/in waiver-specified or regulatory timeframes. N: # substantiated A/N/E cases received from APS where OA and MCO implemented APS recommendations w/in waiver-specified or regulatory timeframes. D: Total # substantiated cases of A/N/E received by OA and MCO from APS.

Data Source (Select one):

Other
If 'Other' is selected, specify:
OA Reports: OIG Report (via unusual incident data base)

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
38G: # and % of participants who received info from OA/MCO about how and to whom to report A/N/E at the time of assessment/ reassessment. N: # of participant records reviewed where there is a signed document that shows the participant received info from OA/MCO about how and to whom to report A/N/E at time of assessment/ reassessment. D: Total # of OA/MCO participant records reviewed.

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

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

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☑ **Other** Specify: EQRO/MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
41G: # and % of participants' deaths as a result of substantiated case of abuse, neglect or exploitation where appropriate follow-up actions were implemented by the OA and MCO. N:# of deaths as a result of a substantiated case of A/N/E where appropriate follow-up actions were implemented by the OA and MCO. D:Total # of OA and MCO deaths as a result of a substantiated case of A/N/E.

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports from the OA: OIG Report (via unusual incident data base)

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

Data Aggregation and Analysis:

Responsible Party for data	**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: MCO	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

Performance Measure:
42G: # and % of participants for whom identified critical incidents other than A/N/E were reviewed and approp. corrective measures were taken by OA and MCO. N:# of participants for whom identified critical incidents other than A/N/E were reviewed and corrective measures were approp. taken by the OA and MCO. D:Total # of OA and MCO participants for whom identified critical incidents were reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: OIG Report (via unusual incident data base)

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

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

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

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

Data Aggregation and Analysis:

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

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:
43G: # and % of restraint, seclusion or other restrictive interven. where approp. interven. was made by OA/MCO in accord. w/wvr and w/in wvr-prescribed timeframes. N:# of restraint, seclusion, or other restrictive interven. where approp. interven. was made by OA/MCO in accord. w/wvr and w/in wvr-prescribed timeframes. D: Total # of OA/MCO restraint, seclusion or other restrictive interventions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Unusual Incident data base

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

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

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

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

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

Data Aggregation and Analysis:

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

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:
44G: # and % of HSP Individual Provider evaluations returned reporting satisfaction as stated in the approved waiver. N: # of HSP Individual Provider evaluations completed that report satisfaction as stated in the approved waiver. D: Total # of Individual Provider evaluations completed.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% of the population selected randomly by region
	☐ **Other** Specify:	

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
45G: # and % of participants who received information from the OA and MCO regarding universal precautions. N: # of participant records reviewed where there is a signed document that shows the participant received information from the OA and MCO about universal precautions. D: Total # of OA and MCO participant records reviewed.

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

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

☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% of the population selected randomly by region
	☐ **Other** Specify:	

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

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

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

Data Aggregation and Analysis:

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

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

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

The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The MA will pull the sample annually and adjust the methodology as additional MCOs are enrolled to provide long term services and supports. For critical incidents, the MCOs are required to report 100% of the findings and remediation. These reports will be summarized by the Plans and reported at least quarterly to the MA.

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
38G: The OA/MCO will assure that customers know how to report abuse, neglect or exploitation. This will be demonstrated by correction of case work documentation reflecting customers awareness, including evidence of steps taken to educate the customer. Remediation must be completed within 30 days.

39G: The OA/MCO will follow up all outstanding DHS-OIG referrals and Unusual Incident Reports. Changes in customers' service plans will be made when needed. Remediation must be completed within 30 days.

40G: The OA/MCO will implement the DHS-OIG recommendations for substantiated cases of abuse, neglect or exploitation. Changes in customers' service plans will be made when needed. Remediation must be completed within 30 days.

41G: The cause of death/circumstances would be reviewed by the OA and MCO; need for training or other remediation, including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns. Resolution or remediation timeframe would be case-specific.

42G: The OA and MCO will follow up on identified critical incidents, other than A/N/E, to ensure information was reviewed and corrective measures were appropriately taken. Resolution or remediation will be based on the nature of the concern.

43G: Restraint, seclusion, or other restrictive interventions will be reviewed by the OA and MCO. The need for training or other remediation, including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns. Resolution or remediation timeframe would be case-specific.

44G: If identifying information is available for individual surveys the OA and MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.

45G: If identifying information is available for individual surveys the OA and MCO case managers will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Anonymous survey responses will be used to identify need for system improvement.

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), the Illinois Department of Human Services, Division of Rehabilitation Services (DHS-DRS), as the Operating Agency (OA), and the contracted Managed Care Organizations (MCOs) work in partnership to evaluate the waiver Quality Management System (QMS). This partnership provides analysis to information derived from discovery and collaboratively develops and monitors remediation activities for each of the federal assurances.

The OA and MCO's are responsible for the majority of the data collection to address the Quality Management System discovery and remediation activities. The OA is solely responsible for eligibility and authorizing qualified providers. Therefore, there are distinct performance measures for these functions under the OA. Both the OA and the MCOs are accountable for all other measures. The MA is accountable for the measures in the Administrative Authority appendix. Additional measures have been added under the Administrative Authority appendix that are specific to oversight of the MCOs. The State's system improvement activities are in response to aggregated and analyzed discovery and remediation data collected on each of the waiver performance measures.

The persons with disabilities waiver Quality Management System (QMS) plan is part of an overall quality management plan for the three 1915 (c) waivers operated by the DHS-DRS (OA). The other waivers include the HIV/ AIDS Waiver (control number IL.0202), and the Brain Injury Waiver(control number IL.0329). While some data may be collected during the same on-site provider and case manager reviews, the sample for each waiver is drawn separately and the results are aggregated separately.

The MA's ongoing quality monitoring includes sharing of reports from QIO reviews with the OA as well as directly with the review site. For sites with findings, a sample Corrective Action Plan template and guidance regarding expected remediation are included as well. Review sites must submit a plan of correction to the OA for its review and any necessary follow up or clarification. The OA must provide a copy of its approval of the site's plan of correction to the MA. Other quality monitoring includes the MA's direct validation through random selection that review findings have been remediated.

On a quarterly basis, the MA conducts separate Quality Management Committee (QMC) meetings with the OA and the MCOs to review data collected from the previous quarter and for the year to date. Data are collected on a regular basis and reported as indicated by the performance measures in the waiver. All reports will be provided to MA for review prior to the quarterly meetings. Annual reports are produced identifying trends based on the representative sample and/or 100% review of data.

OA and MCO compliance data are reported by individual performance measures. Data reported includes: level of compliance and timeliness of remediation based on immediate, 30, 60, 90 day increments and any outstanding remediation. The OA also reports on findings from the other two waivers under its umbrella, for comparison purposes.

During quarterly meetings, the MA and the OA or MCO will identify trends based on scope, severity, changes and patterns of compliance by reviewing both the levels of compliance with the performance measures and remediation activities conducted by the OA and the MCOs. Identified trends are discussed and analyzed regarding cause, contributing factors and opportunities for system improvement. Systems improvement is prioritized based on the overall impact to the participants and the program. Systems improvements may be prioritized based on factors such as: the impact on the health and welfare of waiver participants, legislative considerations and fiscal considerations. The OA and the MCOs maintain separate QMC Systems Improvement Logs. Recommendations for system improvements are added to the log(s) for tracking purposes. The OA and the MCOs document the systems improvement implementation activities on their respective logs. The MA assures that the recommendations are followed through to completion. Decisions and time lines for system improvement are based on consensus of priority and specific steps needed to accomplish change. These decisions are documented on the systems improvement log and will be communicated through the sharing of the quarterly meeting summary and the systems improvement log.

ii. System Improvement Activities

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

The processes Illinois follows to continuously evaluate, as appropriate, effectiveness of the QMS are the same as the processes to evaluate the information derived from discovery and remediation activities. The Waiver Quality Management Committee (QMC) System Improvement Log is a dynamic product that is discussed quarterly by key staff of the MA and the OA or MCO regarding progress, updates and evaluation of effectiveness. Effectiveness is measured by impact on performance based on ongoing data collection over time, feedback from participant/guardian interviews, satisfaction surveys, and service providers. Multiple years of data collection will allow the State to evaluate the effectiveness of system improvements over time.

System design changes may be specific to the OA, the MCOs, or both. Meeting with all parties annually provides an arena to see the system holistically and determine how well the system design changes are working and what areas need further improvement. Decisions that are made as a result of these meetings will be tracked on the QMC Systems Improvement Log.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

One QMC meeting a year is a combined meeting where the MA, the OA, and the MCOs meet and discuss statewide issues impacting the waiver. During this annual meeting, the OA and the MCOs will provide an overview of the previous year's activities and a discussion of whether changes are needed to the Quality Management Strategy. There will be five primary focus areas: These areas are described below.
1)Structure of the QMC: The group reviews the structure of the QMC to determine if it is effective.
2)Trend Analysis: The group will evaluate the processes for identifying trends and patterns to assure that issues are being identified.

3)Systems Improvement Log: The group reviews the QMC Systems Improvement Log to assure that all recommendations have been implemented in accordance with agreed upon time lines, and if not, whether there is justification.
4)System Improvement Priorities: The methods for determining system improvement priorities is evaluated to determine its effectiveness.
5)Performance Measures: The entities will determine whether to make changes in existing performance measures, add measures, or discontinue measures. Other elements of performance measures will also be reviewed for effectiveness, including: the frequency of data collection, source of data, sampling methodology, and remediation.

The State will continually strive to increase the compliance rate of each performance measure. While the target compliance rate for each performance measure is 100%, the State realizes that it may take multiple system changes over several years to reach the goal of 100% compliance.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) Requirements concerning the independent audit of provider agencies;
DHS/DRS completes a review of each homemaker and adult day care provider at a minimum of every two years to ensure compliance with program regulations. The compliance review is conducted on all agencies that have current rate agreements with DHS/DRS for the purpose of determining compliance and/or continued compliance with the Administrative Code: Title 89: Social Services, Chapter IV: Department of Human Services, Subchapter d: Home Services Program, Part 686 Provider Requirements, Type Services, and Rates of Payment. The Department also reserves the right to require the Homemaker Agency to engage an independent certified public accounting agency to verify the information and data submitted by the Homemaker Agency if the department is in possession of evidence to suggest the information and data sent is inaccurate, incomplete, or fraudulent. This audit will be performed at the Homemaker Agency''s expense.

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.

i. Per 89 IL Admin Code 686.10, Personal Assistant (PA) Requirements, personal assistants must demonstrate that they meet the required qualifications in several forms which must be signed by the Personal Assistant and the Customer and turned in to the waiver program as the first part of the OA provider enrollment process for Personal Assistants. This includes the Individual Provider Standards form as well as the Individual Provider Payment Policies form.

ii. On one of these two forms, the Individual Provider Payment Policies, the PA must assure that he or she will provide services in accordance with the participant service plan which specifies the frequency, amount and duration of services to be provided. This form also requires the Personal Assistant to assure that he or she will abide by the limits of service provision as also specified in this section of the Administrative Code.

iii. The waiver program has initiated the Electronic Visit Verification system (described in response to CMS's informal questions) as a means to better assure that Personal Assistants are in the participants' homes at the beginning and end of their work shifts. The already existing payment system then checks to make sure that there is an eligible participant and that hours billed are within the limits of the eligible participant's service plan. Completing forms to be able to use the Electronic Visit Verification are another part of OA provider enrollment.

At the time of reassessment, there is a visual review of the participant's physical condition and that of his or her environment for evidence that the tasks which are supposed to be performed by the participant's Personal Assistants

have been performed, as well as an interview with the participant regarding his or her satisfaction with his or her Personal Assistant(s) using the annual Personal Assistant Evaluation form.

The waiver also has more systematic ways to check for fraud as it relates to service provision by Personal Assistants. For example, the program receives monthly reports which show that Personal Assistants may have provided services when a participant was in the hospital or nursing home or after participant death. Any indication that Personal Assistants are not providing the correct hours of service and performing the correct tasks for eligible participants are followed up on promptly and require inappropriate payments be repaid and backed off Medicaid claim. In addition, where there is indication that Personal Assistants have sought inappropriate payments, the OA takes corrective actions up to and including preventing the Personal Assistant from providing any future services in the program.
Agency scrutiny is triggered in several situations, including where there are complaints about no-show homemaker workers, where participants are billed for more services than are on the service plan, and where homemaker workers mention they have not yet had training or are just filling in for someone who actually works at the agency. In addition, agency scrutiny is triggered based on reports the OA gets on totals paid to the agencies: if the reports don't match the information being sent by agency administration, the OA knows that the information may be inaccurate. The OA has also noted instances in which agencies have tried double and triple billing for the same month or for the same participant, or when agency bills contain participant names that are no longer being served or perhaps were never served. These billings are additional examples of evidence suggesting fraudulent information.

In addition to the audits required by law, DRS also reviews fiscal activity for cases that are reviewed for quality assurance. Also, to ensure proper identification of customers and providers, all customers' social security numbers are verified for accuracy through the Social Security Administration database, and all providers' employer identification numbers are likewise verified prior to enrollment as a Medicaid provider.

(b) The financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits;

The Medicaid Agency has implemented oversight procedures that provide increased assurance that claims are coded and paid in accordance with the reimbursement methodology specified in the waiver. These processes enable staff to monitor the financial aspects of the Persons with Disabilities waiver from a global perspective, rather than review a sample of paid claims. The Medicaid Agency determined that reviewing a sample of paid claims was of limited effectiveness and would not likely disclose problematic billings, patterns and/or trends.

The State has mechanisms in both the MA and OA to recognize whether a provider is a certified biller. The MA has an elaborate IT system which records whether the provider documentation has been received and reviewed and for what period of time the certification is valid. This information then becomes an IT edit for all subsequent financial transactions for this provider for the period that the certification is valid. At the expiration date, no further payments or claims can be made by the MA for this provider until recertification is completed and recorded on the IT system.

The OA has an equally elaborate IT recording and edit system. The MA's certification is also recorded in the OA system along with the OA's own required enrollment information. The OA's EVV timekeeping and billing system for PA's will not take recorded start and stop times until the PA has completed all enrollment information for both the MA and the OA. Without that information, PA's cannot be paid. The fee schedule is posted at http://www.dhs.state.il.us/page.aspx?item=83520.

The Medicaid Agency staff utilizes its Data Warehouse query capability to analyze the entire dataset of paid waiver claims. The Medicaid Agency utilizes an exception report and review format as a component of the agency's financial accountability activity. Agency staff have constructed database queries that encompass waiver eligibility, coding and payment criteria. Based on these criteria, twice a year the Medicaid Agency conducts analysis of all paid claims and only the claims that were not paid in accordance with set parameters are identified and extracted. The identified exceptions are printed out with all relevant service data. Current exception reports identify paid claims for waiver services to clients who were in a nursing home or who are deceased. In addition to the exception reviews of waiver claims, Medicaid Agency staff conduct targeted reviews of individual waiver services, utilization of waiver services by individual recipient and billing trends and patterns of providers. These reviews are usually conducted on an impromptu basis.

The results of all financial reviews are presented to Operating Agency personnel under cover memos with supporting claim detail. The Operating Agency will advise the Medicaid Agency of corrective actions taken, including adjustments, for all service claims identified by the reviews that were not paid in accordance with defined parameters.

The Medicaid and Operating agencies work cooperatively to review rates and provider claims. The Medicaid agency implements procedures that provide assurance that claims will be coded and paid in accordance with the reimbursement methodology specified in the waiver.

For participants enrolled in an MCO, the Medical Agency (MA)'s internal and external auditing procedures will ensure that payments are made to a managed care entity only for eligible persons who have been properly enrolled in the waiver.

The Plans are responsible for reviewing payments made directly to providers for waiver services as part of the ICP. The Plans must have an internal process to validate payments to waiver providers. This includes the claims processing system verifying an individual's waiver eligibility prior to paying claims. This will be reviewed in the Readiness Review.

Post-payment plans of care and financial reviews are also conducted. Additionally, the Plans will implement call-in checks for some waiver services to verify a provider was on-site as required during the specified time(s) and post-service verification forms for participants to validate they received services.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*
   i. **Sub-Assurances:**
      a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
47I: # and % of payments that were paid for services that were specified in the participant's service plan. N: # of payments made to the OA and MCO that are specified in the participant's service plan. D: Total # of OA and MCO payments.

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

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Non-Representative Sample
	☑ **Other** Specify: Semi-Annually	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MCO	☑ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☑ **Other** Specify: Non-Representative Sample
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MCO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-Annually

Performance Measure:
46I: # and % of payments that were paid for participants who were enrolled in the waiver on the date the service was delivered. N: # of payments to the OA and MCO that were paid for participants who were enrolled in the waiver on the date the service was delivered. D: Total # of OA and MCO payments.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Medical Data Warehouse

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Semi-Annually	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Encounter Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MCO	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MCO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-Annually

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
49I: Number and percent of rates consistent with the approved rate methodology over the five year waiver cycle. N: Number of rates consistent with approved rate methodology for the five year waiver cycle. D: Number of approved rates.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Medical Data Warehouse

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Semi-annually	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Encounter Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MCO	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MCO	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: semi-annually

Performance Measure:
48I: # and % of payments that were paid using the correct rate as specified in the waiver application. N: # of OA and MCO payments using the correct rate as specified in the waiver application. D: Total # of OA and MCO payments.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MMIS Medical Data Warehouse

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☑ **Other** Specify: Semi-annually	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Encounter Data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: MCO	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: MCO	☐ **Annually**

☐	**Continuously and Ongoing**
☑	**Other** Specify: Semi-annually

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Medicaid agency, HFS, will conduct routine programmatic and fiscal monitoring for both the OA and the MCOs.

For those functions delegated to the OA and the MCOs, the MA is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by the OA and MCOs.

The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the OA and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a 5% margin of error. The MA will pull the sample annually and adjust the methodology as additional MCOs are enrolled to provide long term services and supports.

For the administrative claims review, the Medicaid agency reviews the entire DHS claim to Medicaid administrative costs.

For the waiver claims review, the Medicaid Agency (HFS) staff utilize the Data Warehouse query capability to analyze the entire dataset of paid waiver claims. The Medicaid Agency utilizes an exception report and review format as a component of the agency's financial accountability activity. Agency staff have constructed database queries that encompass waiver eligibility, coding and payment criteria. Based on these criteria, twice a year the Medicaid Agency conducts analysis of all paid claims and only the claims that were not paid in accordance with set parameters are identified and extracted. This review will include capitation payments made to MCOs and encounter claims submitted by MCOs.

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in HFS' contracts with Integrated Care Program MCOs that provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc. Through its contract with the EQRO, the MA monitors both compliance of PMs and timeliness of remediation for those waiver participants enrolled in an MCO through consumer surveys and quarterly record reviews. Participants in MCOs are included in the representative sampling.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
46I:The MA will require the OA to void the federal claim for services provided prior to the customers' waiver enrollment. Remediation must be completed within 30 days. The MA will adjust the federal claim for services provided by the MCO prior to the customers' waiver enrollment. Remediation must be completed within 30 days.

47I: The OA/MCO will determine whether the service was authorized. If authorized, the OA/MCO will revise customer service plan; If not authorized, the OA/MA will void the federal claims that were not consistent with service plans. Remediation must be completed within 30 days.

48I: The MA will require the OA to either recoup the overpayment or repay at correct rate. If necessary, will also adjust the federal claim. Remediation must be completed within 30 days. The MA will require the MCO to recoup the overpayment or repay at correct rate. Remediation must be completed within 30 days.

49I: The MA will require the OA to either recoup the overpayment or repay at correct rate. If necessary, will

also adjust the federal claim. Remediation must be completed within 30 days. The MA will require the MCO to recoup the overpayment or repay at correct rate. Remediation must be completed within 30 days.

ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Bi-annually

c. **Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Department of Healthcare and Family Services (HFS), Illinois' State Medicaid Agency, retains and exercises final authority over payment rates. It does so in collaboration with the waiver's operating agency, the Illinois Department of Human Services, Home Services Program, which develops the proposed rates and shares the proposed rates and methodology with HFS for its approval. Rates of payment for program services since the initial 1915(c) waiver was approved have been established and updated as described below.
The rates are available to the public through the OA's website: http://www.dhs.state.il.us/page.aspx?item=83520

Personal Assistant: Until July 2003, Personal Assistants were paid Illinois minimum wage as required by state statute and as formally established by the General Assembly in the Home Services Program (HSP) enabling legislation (20 ILCS 2405/3(f)) [originally(g)]. In March 2003, following a decision by the State Labor Relations Board, the Governor of Illinois signed Executive Order 2003-8 requiring an election to determine labor representation of personal assistants. Service Employees International Union Local 880 (SEIU) won the election and was recognized

as the sole and exclusive bargaining unit for personal assistants in the HSP. Negotiations commenced and a four year agreement was signed which specified the rates of payment for that time period. The Labor Relations Act was formally changed July 26, 2003, to specify SEIU's status in this regard. In July 2007, a second four year agreement was negotiated which likewise specified rates of payment for the contract period. A third agreement for a three year contract period became effective in July 2011. Although that agreement should have expired in July 2014, negotiations continue so the rate in effect in June 2014 continues pending completion of current negotiations.

The SEIU agreement indicates that hourly direct care staff rates receive periodic flat rate adjustments. In accordance with recent FLSA regulations, the State also allows for overtime and travel reimbursement to personal assistants. To account for overtime and travel expenses, the personal assistant hourly waiver rate was increased by 3.21%, a figure that represents the projected overall increase in overtime costs as a percentage of overall spending in State Fiscal Year 2015, the most recent year for which the State has complete spending data. The projected overall increase in overtime costs was based on actual 2014 data, the most recent year from which the State's data systems currently provide reliable and full data on that point.

The rates do not include any direct or indirect administrative costs, are not geographically based, and exclude room and board costs. Rates are available to the public through the SEIU website and the Illinois Central Management Services website. The labor agreement is also posted on the OA's website under the HSP.

Home Health Extended State Plan and "Other" Services: Home Health Extended State Plan and "Other" Services include: registered nurses, licensed practical nurses, intermittent nurse visits, HH Aides (CNAs) and therapists (occupational, speech, and physical). The OA pays different rates depending on whether the service is provided by a licensed home health agency or by an independently licensed or certified provider.

Historically, the independently licensed or certified provider rates were negotiated on an individual participant basis with rate ceilings based on the prevailing wage rates for these providers statewide. Beginning in July 2012, the SEIU contract was expanded to include independently licensed or certified providers using a fixed rate schedule for each type of service. Thee rates are available to the public through the SEIU website and the Illinois Central Management Services website in the published labor agreement. The labor agreement is also posted on the OA's website under the HSP. All home health rates are the same statewide except for children's agency rates which differ geographically.

In accordance with recent FLSA regulations, the State also allows for overtime and travel reimbursement to home health service providers. To account for overtime and travel expenses, the individual home health provider hourly waiver rates were increased by 12.86%, a figure that represents the projected overall increase in overtime costs as a percentage of overall spending in State Fiscal Year 2015, the most recent year for which the State has complete spending data. The projected overall increase in overtime costs was based on actual 2014 data, the most recent year from which the State's data systems currently provide reliable and full data on that point.

Homemaker rates are fixed unit rates based on the rates established by the Illinois Department on Aging (IDoA) in the Elderly Waiver (0143). To establish the initial rate in the original, 1982 joint Aging and Disability waiver, IDoA employed a Request for Proposals (RFP) process through which applicants indicated their costs for providing the service and the size of the population each applicant projected it could serve. The rate was then established at one standard deviation above the mean of the weighted costs received. Homemaker service providers are required to expend a minimum of 73% of their total CCP revenues on direct service worker costs. The remaining 27% of revenues may be spent by the provider agencies at their discretion on administrative or program support costs. See 89 Ill. Adm. Code 240.2040.

Expenses that may be counted as direct service worker costs include wages, health coverage, retirement, FICA, uniforms, workers compensation, travel reimbursement, FUTA and unemployment insurance (UI). Program support and administrative expenses include direct service worker supervisor costs, training costs, malpractice insurance, administration staff costs, consultant fees, supplies and equipment, telephone service, occupancy costs and postage. 89 Ill. Adm. Code 240.2050.

Subsequent rates added cost of living adjustments (COLAs) to the previous rates or reflected changes negotiated as part of collective bargaining agreements between the State and the Service Employees International Union (SEIU). The in-home service rates were increased on January 1, 2003, and June 1, 2006, as a result of action taken by the Administration and General Assembly. Effective July 1, 2008, an agreement between the State and SEIU raised the in-home services rate to coincide with the three-step increase in the federal Fair Minimum Wage Act of 2007. Also effective July 1, 2008, the rate was enhanced pursuant to Illinois Public Act 95-713, to cover health insurance costs.

The in-home service rates include administrative costs and direct care staff wages. The rates are not geographically based and do not include room and board.

In-home services rates are reviewed by IDoA annually to ensure budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program. In reviewing fixed unit rates of reimbursement, the State takes into consideration (1) service utilization and cost information, and (2) current market conditions and trend analyses.

Adult Care Day Service rates are based on rates established by the IDoA in their elderly Waiver (0143). The fee-for-service reimbursement rate structure consists of two fixed unit rates, one for ADS and another for ADS transportation. The initial unit rate for ADS was established based on five direct client contact hours per day (excluding transportation), but the unit rate was changed in April 1996, when the definition of an ADS unit was changed to allow one hour to equate to one unit of service to reflect the business practices and operating hours of the participating provider industry as well as client and family preference.

ADS rates include both administrative and direct care costs. They are not geographically based and do not include room and board. Since the original ADS rates were established, they have been updated to include legislatively negotiated cost of living adjustments. Two such updates occurred effective January 1, 2003 (for all ADS rates), and July 1, 2006 (for the transportation component). In addition, ADS rates are reviewed annually by IDoA to ensure budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program.

Emergency Home Response rates are based on the rates established by IDoA in the Elderly Waiver (0143). EHR rates include a one-time installation fee and a separate monthly rate for ongoing EHR services. The rate covers maintaining adequate local staffing levels of personnel, installation, training, signal monitoring, and technical support and repairs.

EHR rates are based on fixed unit rates that were established in 2007, pursuant to a January 2006 Request for Information (RFI) process. Under this process, the Department on Aging solicited input from EHR providers regarding the services they could provide and their costs for doing so. Providers supplied quotes that covered costs associated with installation, monthly service rates and removal fees, any special pricing arrangements that could be offered (e.g. volume discount, reduced rates based on need, and a description of any region-specific packages/units that could be offered at a discount). Thirteen vendors responded to the RFI with similar products and services. With the highest and lowest quotes disregarded as outliers, the average quotes for installation and monthly monitoring were $31.25 and $38.40, respectively. Multiple providers also noted that their rates were negotiable or that they could match competitors' rates, and some offered discounts for second users. For monthly monitoring, the lowest quoted rate (after disregarding the outlier) was $28.00. Based on these factors, the IDoA chose, and HFS approved, rates of $30.00 for installation and $28.00 for monthly monitoring. Illinois has seven vendors offering this service statewide at these rates.

Rates are not geographically based and do not include room and board. EHR rates are reviewed annually to ensure budget sustainability, appropriateness, compliance with service requirements, and compliance with any new federal or state statutes or rules affecting the program

Home Delivered Meals: The home-delivered meals rates are standardized and are based on rates set under Title III of the Older Americans Act. The administrative rule specifies that the cost of HDM can be no more than what it would cost for a personal assistant to prepare the meal. The rates are not geographically-based and do not include direct or indirect administrative costs. The rate is subject to COLA when enacted and published on the OA's website under HSP.

Respite service rates methodologies are based on the established rate for each included service provider type. Rates are published on the OA's website under HSP.

Environmental Accessibility Adaptations & Specialized Medical Equipment and Supplies: Payments are subject to prior approval by the OA. For any item costing more than $1500, three bids are required and the lowest bidder is selected. If the lowest bidder cannot provide timely services, the next lowest bid may be selected. If three bids cannot be obtained or a bid is the sole source for lack of available vendors, a formal justification as to why three bids were not secured is required. Rate maximums, above which supervisory approval and written justification is required, are published on the OA's website under HSP.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Provider Payment

The operating agency (DHS) pays the provider directly. The three-party Medicaid waiver provider agreement is on file with the Medicaid agency and it allows the provider to voluntarily reassign payment to the operating agency. If a provider chooses to receive payment directly from the Medicaid agency, the provider will sign the standard Medicaid provider agreement (HFS 1413). Providers may receive payment directly from the Medicaid agency, if they choose not to voluntarily reassign payment to the Operating agency.

DHS maintains a computerized payment system that includes service plan authorization for each individual, payments to provider agencies, units of service delivered to each eligible individual, and payment and claiming rates per unit of service.

DHS authorizes services, in advance of service delivery. Both the provider and the customer report and certify that the service was delivered and the HSP counselor approves payment for the service. A combination authorization/voucher document is utilized in this payment process and constitutes a legal agreement between DHS and the provider. Services are authorized and vouchered for no more than one calendar month.

The DHS payment system contains edits to ensure that payments are made only when the individual is authorized for the program services delivered, via a service plan that specifies the program services, the provider of the program services, and the amount of services authorized.

Operating agency claims processing
Payments are made by the State of Illinois Comptroller's Office from DHS' appropriation. DHS then submits the amount of expenditures for Medicaid eligible recipients to HFS for submission of federal financial participation.

Medicaid agency claims processing
The operating agency waiver claiming data is transmitted to the Medicaid agency via computer tape exchange. The waiver subsection of the MMIS matches the individual against the recipient eligibility file to ensure Medicaid eligibility on the date of service and matches the provider against the provider enrollment file to ensure that the provider is enrolled as a waiver provider with the Medicaid agency. The waiver MMIS includes edits for waiver claims that conflict with other waivers, hospitals, nursing home, hospice facilities, or ICF/MR claims and rejects waiver claims that are duplicative or incompatible.

The Medicaid agency pays the Managed Care Organizations (Plans) a monthly capitated rate for waiver services.

This payment is generated from MMIS based on participants' eligibility in the database system for waiver services. Waiver providers receive payment for services by billing the Plans. The Plans issue payments based on claims received and verification of individual participant waiver eligibility. These claims paid by the MCO are then submitted through the State's MMIS system as encounter data.

Provider rates may be viewed at this link: http://www.dhs.state.il.us/page.aspx?item=83520

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Provider billings are validated by DHS to verify the effective date of the customer's authorization for services as included in an approved plan of care. Customers also sign time sheets to verify that services were performed in accordance with the plan of care. Paid claims are passed through to HFS and MMIS processing edits are initiated for Medicaid and waiver eligibility. Lastly, HFS performs post-payment plan of care and financial reviews.

Monthly capitated rates are paid by the Medicaid Agency to the Managed Care Organizations (Plans). This payment is generated by the MMIS based on participants' eligibility for waiver services as identified in the database system. The Plans only receive payment for individuals eligible for waiver services. The MCO payment process is automated to generate a monthly capitation to the health plans based on the rate cell of each enrollee each month. The State reviews to ensure the accurate rate is entered into the system, and also spot checks payment reports to ensure payments are made correctly. In addition, the MCOs are required to review their monthly payment and report to the Department any discrepancies.

The State has a monthly capitation program that reads the State's Recipient Database to determine who is enrolled with a particular MCO. The program includes logic that uses the enrollee's eligibility criteria to determine the appropriate rate cell to be used in generating the payment. As a result of this process, a file is created of MCO schedules which are then sent on to the Comptroller for payment. Once the payment has been made by the Comptroller, a file is sent back to HFS by the Comptroller that includes a warrant number and date. HFS then creates a HIPAA 820 files for each MCO. The 820 file contains the detailed payment information on each of the MCO's enrollees.

The Plans are required to have internal processes to validate payments to waiver providers. The Plans' claims processing system must verify an individual's waiver eligibility prior to paying claims.

Post-payment plans of care and financial reviews are also conducted, to ensure that plans of care are consistent with needs identified in individuals' assessments. Additionally, the Plans will implement call-in checks for some waiver services to verify a provider was on-site as required during the specified time(s) and post-service verification forms for participants to validate they received services.

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 Operating Agency makes payments from a central computer system. Claims are edited and then sent to HFS for further editing and for Medicaid claiming. The audit trail is established through state agency approved rates, service plan authorizations, documentation of service delivery, and computerized payment and claiming systems cross-matched with the MMIS.

Monthly capitated rates are paid by the Medicaid Agency to the Managed Care Organizations (Plans). This payment is generated by the MMIS based on participants'eligibility for waiver services as identified in the database system. The Plans only receive payment for individuals eligible for waiver services.

- ○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid**

program.

☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The limited fiscal agent is a function of the operating agency.

The provider signs the three-party Medicaid provider agreement that allows voluntary reassignment of pay. The operating agency makes payments directly to providers of waiver services and certifies those expenditures to the Medicaid agency.

The operating agency explains to providers that the waiver agreement voluntarily reassigns payment responsibility to the operating agency and that they have the option to bill HFS, directly, if they choose.

Illinois has developed a state operated payroll system for independent providers or providers that are consumer directed. The customers must sign service calendars to verify the hours worked. The independent (non-agency) provider sends the hours worked to the HSP District office for review and approval. The District enters the payment onto the Virtual Case Management System that includes internal edits to assure that the correct rates and the claims are within the service cost maximum. The DHS state operated payroll system pays independent providers twice monthly. The payroll system withholds unemployment, FICA, union dues and other deductions as requested by the providers.

Services - The Operating Agency passes the detail expenditure data once a month via an electronic tape to the Department of Healthcare and Family Services (DHFS). DHFS is the Single Statewide Medicaid claiming agency for the State of Illinois. The data is fed into the Medicaid Management Information System (MMIS) and is subject to edits to ensure the information provided is accurate and that the services/providers are eligible for federal match under Title XIX. Should any claims have inaccurate information, those claims are rejected by the system and a file of the rejected claims is passed back to the Operating agency for their review. Claims that pass through the system without error filter down to the MARS reporting unit. The MARS unit is responsible for generating the reports to the Bureau of Federal Finance (BFF) who use the reports to claim Medicaid expenditure data quarterly on the CMS 64. MARS also has a series of edits and codes that are used to filter data to ensure accuracy and to determine to what program the expenditure should be reported. The BFF report the expenditures on the CMS 64 on a quarterly basis 30 days after the quarter ends.

Federal Draws from the Medicaid Grant - In accordance with the Cash Management Improvement Act (CMIA), the BFF draws down federal monies from the Title XIX grant for the waiver on a weekly basis and deposits the funds into the General Revenue Fund (GRF). The amount to be drawn is an estimate derived by using historical expenditure data. Once the CMS 64 is completed at the quarter's end, the BFF reconciles the estimated cash draw to the actual expenditures reported on the CMS 64. The reconciling expenditure amount is either added to or subtracted from the grant award depending on whether or not the adjustment is over or under the original estimated amount.

☑ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Not applicable

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments

are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- (●) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ( ) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ( ) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State**

recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- (●) **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ( ) **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ( ) **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- (●) **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

Department of Human Services-Division of Rehabilitation 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*:

- ☐ **Appropriation of State Tax Revenues to the State Medicaid agency**
- ☑ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The operating agency receives the non-federal share through the General Revenue Fund appropriations.

- ☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**

☐ **Co-Payment**
☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

◉ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

○ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	14821.53	7985.51	22807.04	29982.36	8425.31	38407.67	15600.63
2	15334.67	8177.68	23512.35	31272.74	8063.88	39336.62	15824.27
3	15475.97	8374.47	23850.44	32618.65	7717.95	40336.60	16486.16
4	15566.19	8576.00	24142.19	34022.48	7386.87	41409.35	17267.16
5	15656.63	8782.38	24439.01	35486.73	7069.98	42556.71	18117.70

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	33950	33950
Year 2	34993	34993
Year 3	36068	36068
Year 4	37177	37177
Year 5	38320	38320

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay was based on the actual length of stay average over the span of five waiver years, beginning with 10/01/09.

Although the waiver participant count shows growth, ALOS is also a function of billed and claimed services and the number of participants billing/claiming each month. Detailed analysis of ALOS for FFY09 through FFY15 shows relatively flat ALOS ranging from 289 days to 294 days, but not in the sequential order one would expect. The weighted average of 292 days is therefore a defensible figure to use for the five years of waiver renewal. The State will be alert to any emergence of different ALOS patterns.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Estimates are based on an analysis of data for FY2010 through FY2014 (estimated) historical average percent of change, comprised of rate increases and case mix changes of current utilization and costs among participants enrolled in the waiver. These estimates were subsequently projected forward using the same historical percentage of growth for the total unduplicated client count for fee-for-service and applied the same percent of growth to each individual waiver service.

The current estimates for factor D must be updated to reflect revised projected enrollment numbers, and also to reflect overtime and travel reimbursement in accordance with recent FLSA regulations. To arrive at these projections for heavily used services, the State derived a yearly increase based on a trend of utilization data for the five years ending in 2015. For little-used services, the State projected no growth, both due to the low usage and observed growth and because the smaller sample size would skew a five-year trend.

To incorporate the cost of overtime into the waiver service rates, the State developed weighted percentage increases to the affected rates based on actual data from State Fiscal Year 2014 spending. The State expressed projected overtime costs as a percentage of Fiscal Year 2015 waiver costs to arrive at a waiver rate increase of 3.21% for personal assistants and 12.86% for home health service providers. These rates should be added to rates or total spending for Waiver Years 3-5. For Waiver Year 2, only 75% of these rates were used (2.41% and 9.65%, respectively) because overtime is paid for only nine months. The State opted to project all home health services together, rather than separately, because the relatively low utilization for each service type required combination to create a better sample size for projection.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Fee-for-service Population:

We have assumed the cost per unit will remain the same. We have calculated the units per user by adjusting the aggregate number of units in both the fee-for-service and MCO populations. The percentage for D' is 2.4% increase.

MCO Population:

We have distributed an average monthly capitation rate of $1,700 across the rate categories. We have assumed that the average length of stay on the waiver would be the same for both the fee-for-service and MCO populations. We have assumed that the average units per user would be consistent with the current Factor D. We have assumed the same ratio of users per service based on the current Factor D. The cost per unit of service was used as the residual calculation after determining the other variables.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is the institutional cost per person for adults. Factor G is estimated to increase by 4.30% each year for WY'10 - WY'14 due to utilization. The 4.30% increase incorporates both case mix increases and rate increases to Nursing Homes for each waiver year.

For participants receiving nursing facility services through a Managed Care Organization (MCO), a capitation rate specific to nursing facility services is used. The capitation rate was developed based on historical fee-for-service nursing facility costs from state fiscal years (SFY) 2008 through 2011. The historical nursing facility experience was trended forward to the contract rating years.

Since not all nursing facility residents are enrolled in an MCO, Factor G was developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G Prime is estimated to decrease by 4.28% for the next five waiver years. This percentage is based upon the average historical percent change for WY'10 - WY'14 (estimated). Actual ancillary expenditures per capita for Institutional residents and carried forward to WY'14- WY'20. These estimates include case mix and rate increases. Factor G Prime is based on ancillary services received by the comparable population of nursing home residents over age 60.

The projections were based on utilization of Medicaid ancillary services for waiver participants and nursing facility participants. Waiver participants receive additional services that are covered by non-Medicaid funded entities. Examples include Title III services, home-delivered meals, and medication monitoring services provided through various demonstration projects. The combination of waiver services and other services, as described above may assist in lowering the need for the Medicaid ancillary services, thus resulting in D' projections being lower than G' projections.

The capitation rate nursing facility residents enrolled in Managed Care Organization includes both nursing facility services, as identified in Factor G, and ancillary medical and pharmacy services. The capitation rate is certified as actuarially sound. The capitation rate developed based on historical fee-for-service costs for ancillary services for nursing facility residents from state fiscal years 2010 through 2014. The historical ancillary service expenditures were trended forward to the contract rating years. The capitation rate also includes an administrative and risk load appropriate for the MCO.

Since not all nursing home residents are enrolled in an MCO, Factor G was developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services
Adult Day Care
Homemaker
Individual Provider (Personal Assistant - Non Agency)
Respite
Home Health Aide
Occupational Therapy
Physical Therapy
Speech Therapy
Environmental Accessibility Adaptations
Home Delivered Meals
In-Home Shift Nursing
Intermittent Nursing

Personal Emergency Response System
Specialized Medical Equipment

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**2062733.22**
Adult Day Care	☐	Day	169	925.00	9.02	**1410051.50**	
Adult Day Care Transport	☐	Day	130	205.00	8.30	**221195.00**	
Adult Day Care Capitated	☑	Day	28	861.00	9.72	**234329.76**	
Adult Day Care Transport Capitated	☑	Day	62	72.00	6.35	**28346.40**	
Adult Day Care MMAI	☑	Day	14	827.00	9.70	**112306.60**	
Adult Day Care Transport MMAI	☑	Day	14	193.00	8.93	**24128.86**	
Adult Day Care MMAI Opt Out	☑	Day	5	617.00	9.02	**27826.70**	
Adult Day Care Transport Opt Out	☑	Day	4	137.00	8.30	**4548.40**	
Homemaker Total:							**49232949.37**
HomeMaker	☐	Hour	3131	685.00	17.14	**36760757.90**	
HomeMaker Capitated	☑	Hour	581	741.00	20.67	**8898869.07**	
HomeMaker MMAI	☑	Hour	238	645.00	18.43	**2829189.30**	
HomeMaker MMAI Opt Out	☑	Hour	95	457.00	17.14	**744133.10**	
Individual Provider (Personal Assistant - Non Agency) Total:							**432939550.41**
Personal Assistant	☐	Hour	19345	1281.97	13.98	**346699940.91**	
Personal Assistant Capitated	☑	Hour	3478	1093.00	15.06	**57249897.24**	
Personal Assistant MMAI	☑	Hour	1282	1141.00	15.03	**21985312.86**	
Personal Assistant MMAI	☑	Hour	586	855.00	13.98	**7004399.40**	

Opt Out							
Respite Total:							**988878.43**
RN	☐	Hour	6	60.00	29.55	**10638.00**	
LPN	☐	Hour	4	120.00	25.47	**12225.60**	
HomeMaker	☐	Hour	23	145.00	17.14	**57161.90**	
Personal Assistant	☐	Hour	310	175.00	13.98	**758415.00**	
Home Health Aide (CNA)	☐	Hour	13	220.00	13.75	**39325.00**	
Adult Day Care	☐	Day	1	5.00	9.00	**45.00**	
Adult Day Care Transport	☐	Day	1	5.00	8.30	**41.50**	
RN Capitated	☑	Hour	1	18.00	31.84	**573.12**	
LPN Capitated	☑	Hour	1	46.00	27.44	**1262.24**	
HomeMaker Capitated	☑	Hour	4	190.00	18.47	**14037.20**	
Personal Assistant Capitated	☑	Hour	18	175.00	15.06	**47439.00**	
Home Health Aide (CNA) Capitated	☑	Hour	2	224.00	14.82	**6639.36**	
Adult Day Care Capitated	☑	Day	1	5.00	9.70	**48.50**	
Adult Day Care Transport Capitated	☑	Day	1	5.00	8.94	**44.70**	
RN MMAI	☑	Hour	1	15.00	31.78	**476.70**	
LPN MMAI	☑	Hour	1	86.00	27.39	**2355.54**	
HomeMaker MMAI	☑	Hour	1	78.00	18.43	**1437.54**	
Personal Assistant MMAI	☑	Hour	4	175.00	15.03	**10521.00**	
Home Health Aide (CNA) MMAI	☑	Hour	1	299.00	14.79	**4422.21**	
Adult Day Care MMAI	☑	Day	1	5.00	9.68	**48.40**	
Adult Day Care Transport MMAI	☑	Day	1	5.00	8.93	**44.65**	
RN MMAI Opt Out	☑	Hour	1	40.00	29.55	**1182.00**	
LPN MMAI Opt Out	☑	Hour	1	80.00	25.47	**2037.60**	
HomeMaker MMAI Opt Out	☑	Hour	1	97.00	17.14	**1662.58**	
Personal Assistant MMAI Opt Out	☑	Hour	9	117.00	13.98	**14720.94**	
Home Health Aide (CNA) MMAI Opt Out	☑	Hour	1	147.00	13.75	**2021.25**	
Adult Day Care MMAI Opt Out	☑	Day	1	3.00	9.00	**27.00**	
Adult Day Care Transport MMAI	☑	Day	1	3.00	8.30	**24.90**	

Opt Out							
Home Health Aide Total:							**4822265.72**
Home Health Aide Agency(CNA)	☐	Hour	215	573.86	13.75	**1696473.62**	
Home Health Aide Independant (CNA)	☐	Hour	153	821.28	17.22	**2163793.56**	
Home Health Aide Agency Capitated	☑	Hour	36	555.00	15.45	**308691.00**	
Home Health Aide Agency MMAI	☑	Hour	14	449.00	14.79	**92969.94**	
Home Health Aide Agency MMAI Opt Out	☑	Hour	7	383.00	13.75	**36863.75**	
Home Health Aide Independant Capitated	☑	Hour	48	330.00	18.55	**293832.00**	
Home Health Aide Independant MMAI	☑	Hour	12	821.00	18.52	**182459.04**	
Home Health Aide Independant MMAI Opt Out	☑	Hour	5	548.00	17.22	**47182.80**	
Occupational Therapy Total:							**39642.38**
Occupational Therapy	☐	Hour	3	10.00	53.00	**1590.00**	
Occupational Therapy Capitated	☑	Hour	146	4.00	64.10	**37434.40**	
Occupational Therapy MMAI	☑	Hour	1	2.00	56.99	**113.98**	
Occupational Therapy MMAI Opt Out	☑	Hour	1	7.00	72.00	**504.00**	
Physical Therapy Total:							**96436.23**
Physical Therapy	☐	Hour	2	26.00	53.00	**2756.00**	
Physical Therapy Capitated	☑	Hour	287	5.00	64.35	**92342.25**	
Physical Therapy MMAI	☑	Hour	1	2.00	56.99	**113.98**	
Physical Therapy MMAI Opt Out	☑	Hour	1	17.00	72.00	**1224.00**	
Speech Therapy Total:							**1861.14**
Speech Therapy	☐	Hour	1	10.00	53.00	**530.00**	
Speech Therapy Capitated	☑	Hour	1	4.00	64.31	**257.24**	
Speech Therapy MMAI	☑	Hour	1	10.00	56.99	**569.90**	
Speech Therapy MMAI Opt Out	☑	Hour	1	7.00	72.00	**504.00**	
Environmental Accessibility Adaptations Total:							**731502.60**
Environmental Accessibility Adaptations	☐	Unit	88	1.00	6500.00	**572000.00**	

Environmental Accessibility Adaptations Capitated	✓	Unit	15	1.00	7003.57	**105053.55**	
Environmental Accessibility Adaptations MMAI	✓	Hour	5	1.00	6989.81	**34949.05**	
Environmental Accessibility Adaptations MMAI Opt Out	✓	Hour	3	1.00	6500.00	**19500.00**	
Home Delivered Meals Total:							**4854064.76**
Home Delivered Meals		Day/week	1160	232.00	15.00	**4036800.00**	
Home Delivered Meals Capitated	✓	Day/week	193	232.00	12.56	**562386.56**	
Home Delivered Meals MMAI	✓	Day/week	83	208.00	10.05	**173503.20**	
Home Delivered Meals MMAI Opt Out	✓	Day/week	35	155.00	15.00	**81375.00**	
In-Home Shift Nursing Total:							**4865044.65**
RN Agency		Hour	33	792.04	29.55	**772357.81**	
LPN Agency		Hour	57	450.00	25.47	**653305.50**	
Multi Customer Nurse		Hour	2	1748.00	47.28	**165290.88**	
RN Independant		Hour	43	495.20	32.03	**682034.01**	
LPN Independant		Hour	60	1100.00	24.76	**1634160.00**	
RN Agency Capitated	✓	Hour	41	154.00	7.52	**47481.28**	
LPN Agency Capitated	✓	Hour	15	538.00	32.62	**263243.40**	
Multi Customer Nurse Capitated	✓	Hour	1	1.00	50.94	**50.94**	
RN Independant Capitated	✓	Hour	6	774.00	34.51	**160264.44**	
LPN Independant Capitated	✓	Hour	10	849.00	26.68	**226513.20**	
RN Agency MMAI	✓	Hour	2	391.00	34.34	**26853.88**	
LPN Agency MMAI	✓	Hour	3	338.00	27.39	**27773.46**	
Multi Customer Nurse MMAI	✓	Hour	1	1.00	50.84	**50.84**	
RN Independant MMAI	✓	Hour	3	142.00	34.44	**14671.44**	
LPN Independant MMAI	✓	Hour	4	546.00	26.63	**58159.92**	
RN Agency MMAI Opt Out	✓	Hour	1	528.00	29.55	**15602.40**	
LPN Agency MMAI Opt Out	✓	Hour	2	300.00	25.47	**15282.00**	
Multi Customer Nurse MMAI Opt Out	✓	Hour	1	1165.00	47.28	**55081.20**	
RN Independant	✓	Hour				**10569.90**	

MMAI Opt Out			1	330.00	32.03		
LPN Independant MMAI Opt Out	✓	Hour	2	733.00	24.76	**36298.16**	
Intermittent Nursing Total:							**1033882.83**
Intermittent Nursing		Hour	160	33.00	65.25	**344520.00**	
Intermittent Nursing Capitated	✓	Hour	783	10.00	83.28	**652082.40**	
Intermittent Nursing MMAI	✓	Hour	13	33.00	70.17	**30102.93**	
Intermittent Nursing MMAI Opt Out	✓	Hour	5	22.00	65.25	**7177.50**	
Personal Emergency Response System Total:							**1143666.29**
Personal Emergency Response		Month	3674	9.00	28.00	**925848.00**	
Personal Emergency Response Install		One Time	350	1.00	30.00	**10500.00**	
Personal Emergency Response Capitated	✓	Month	416	9.00	30.17	**112956.48**	
Personal Emergency Response Install Capitated	✓	One time	58	1.00	32.32	**1874.56**	
Personal Emergency Response MMAI	✓	Month	269	9.00	30.11	**72896.31**	
Personal Emergency Response Install MMAI	✓	One Time	19	1.00	32.26	**612.94**	
Personal Emergency Response MMAI Opt Out	✓	Month	111	6.00	28.00	**18648.00**	
Personal Emergency Response Install MMAI Opt Out	✓	One Time	11	1.00	30.00	**330.00**	
Specialized Medical Equipment Total:							**378610.71**
Specialized Medical Equipment		Unit	155	1.30	1225.00	**246837.50**	
Specialized Medical Equipment Capitated	✓	Unit	30	1.00	3705.26	**111157.80**	
Specialized Medical Equipment MMAI	✓	Unit	11	1.00	1317.31	**14490.41**	
Specialized Medical Equipment MMAI Opt Out	✓	Unit	5	1.00	1225.00	**6125.00**	

GRAND TOTAL:	**503191088.74**
Total: Services included in capitation:	103312494.55
Total: Services not included in capitation:	399878594.19
Total Estimated Unduplicated Participants:	**33950**

Factor D (Divide total by number of participants):	**14821.53**
Services included in capitation:	3043.08
Services not included in capitation:	11778.46
Average Length of Stay on the Waiver:	292

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**2169988.47**
Adult Day Care	☐	Day	171	942.00	9.02	**1452959.64**	
Adult Day Care Transport	☐	Day	130	205.00	8.30	**221195.00**	
Adult Day Care Capitated	☑	Day	29	861.00	9.91	**247442.79**	
Adult Day Care Transport Capitated	☑	Day	64	72.00	6.47	**29813.76**	
Adult Day Care MMAI	☑	Day	22	827.00	9.89	**179938.66**	
Adult Day Care Transport MMAI	☑	Day	22	193.00	9.10	**38638.60**	
Adult Day Care MMAI Opt Out	☑	Day	1	1.00	0.01	**0.01**	
Adult Day Care Transport Opt Out	☑	Day	1	1.00	0.01	**0.01**	
Homemaker Total:							**50581765.83**
HomeMaker	☐	Hour	3128	685.00	17.14	**36725535.20**	
HomeMaker Capitated	☑	Hour	598	741.00	21.09	**9345358.62**	
HomeMaker MMAI	☑	Hour	372	645.00	18.80	**4510872.00**	
HomeMaker MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
Individual Provider (Personal Assistant - Non Agency) Total:							**463330330.65**
Personal Assistant	☐	Hour	19693	1304.66	14.33	**368175952.22**	
Personal Assistant Capitated	☑	Hour	3582	1093.00	15.36	**60136335.36**	
Personal Assistant MMAI	☑	Hour	2002	1141.00	15.33	**35018043.06**	

Personal Assistant MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Respite Total:							**1027851.90**
RN		Hour	6	60.00	32.40	**11664.00**	
LPN		Hour	12	120.00	27.93	**40219.20**	
HomeMaker		Hour	23	145.00	17.14	**57161.90**	
Personal Assistant		Hour	310	175.00	14.33	**777402.50**	
Home Health Aide (CNA)		Hour	10	220.00	15.08	**33176.00**	
Adult Day Care		Day	1	5.00	9.00	**45.00**	
Adult Day Care Transport		Day	1	5.00	8.30	**41.50**	
RN Capitated	✓	Hour	1	18.00	32.48	**584.64**	
LPN Capitated	✓	Hour	1	46.00	27.99	**1287.54**	
HomeMaker Capitated	✓	Hour	4	190.00	18.84	**14318.40**	
Personal Assistant Capitated	✓	Hour	19	175.00	15.36	**51072.00**	
Home Health Aide (CNA) Capitated	✓	Hour	2	224.00	15.11	**6769.28**	
Adult Day Care Capitated	✓	Day	1	5.00	9.89	**49.45**	
Adult Day Care Transport Capitated	✓	Day	1	5.00	9.12	**45.60**	
RN MMAI	✓	Hour	2	15.00	32.41	**972.30**	
LPN MMAI	✓	Hour	2	86.00	27.94	**4805.68**	
HomeMaker MMAI	✓	Hour	2	78.00	18.80	**2932.80**	
Personal Assistant MMAI	✓	Hour	6	175.00	15.33	**16096.50**	
Home Health Aide (CNA) MMAI	✓	Hour	2	299.00	15.08	**9017.84**	
Adult Day Care MMAI	✓	Day	2	5.00	9.87	**98.70**	
Adult Day Care Transport MMAI	✓	Day	2	5.00	9.10	**91.00**	
RN MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
LPN MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
HomeMaker MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Personal Assistant MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Home Health Aide (CNA) MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Adult Day Care MMAI Opt Out	✓	Day	1	1.00	0.01	**0.01**	

Adult Day Care Transport MMAI Opt Out	✓	Day	1	1.00	0.01	**0.01**	
Home Health Aide Total:							**5259969.58**
Home Health Aide Agency(CNA)		Hour	220	593.95	13.75	**1796698.75**	
Home Health Aide Independant (CNA)		Hour	153	821.28	18.88	**2372382.26**	
Home Health Aide Agency Capitated	✓	Hour	37	555.00	15.76	**323631.60**	
Home Health Aide Agency MMAI	✓	Hour	22	449.00	15.08	**148960.24**	
Home Health Aide Agency MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Home Health Aide Independant Capitated	✓	Hour	37	555.00	15.76	**323631.60**	
Home Health Aide Independant MMAI	✓	Hour	19	821.00	18.89	**294665.11**	
Home Health Aide Independant MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Occupational Therapy Total:							**41056.53**
Occupational Therapy		Hour	3	10.00	53.00	**1590.00**	
Occupational Therapy Capitated	✓	Hour	150	4.00	65.39	**39234.00**	
Occupational Therapy MMAI	✓	Hour	2	2.00	58.13	**232.52**	
Occupational Therapy MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Physical Therapy Total:							**100135.73**
Physical Therapy		Hour	2	26.00	53.00	**2756.00**	
Physical Therapy Capitated	✓	Hour	296	5.00	65.64	**97147.20**	
Physical Therapy MMAI	✓	Hour	2	2.00	58.13	**232.52**	
Physical Therapy MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Speech Therapy Total:							**1024.93**
Speech Therapy		Hour	1	10.00	53.00	**530.00**	
Speech Therapy Capitated	✓	Hour	1	4.00	65.60	**262.40**	
Speech Therapy MMAI	✓	Hour	2	2.00	58.13	**232.52**	
Speech Therapy MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Environmental Accessibility Adaptations Total:							**736191.49**
Environmental							

Accessibility Adaptations	☐	Unit	88	1.00	6500.00	**572000.00**	
Environmental Accessibility Adaptations Capitated	☑	Unit	15	1.00	7143.64	**107154.60**	
Environmental Accessibility Adaptations MMAI	☑	Hour	8	1.00	7129.61	**57036.88**	
Environmental Accessibility Adaptations MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
Home Delivered Meals Total:							**4923207.09**
Home Delivered Meals	☐	Day/week	1131	239.00	15.00	**4054635.00**	
Home Delivered Meals Capitated	☑	Day/week	199	232.00	12.81	**591412.08**	
Home Delivered Meals MMAI	☑	Day/week	130	208.00	10.25	**277160.00**	
Home Delivered Meals MMAI Opt Out	☑	Day/week	1	1.00	0.01	**0.01**	
In-Home Shift Nursing Total:							**4737434.13**
RN Agency	☐	Hour	40	504.62	29.55	**596460.84**	
LPN Agency	☐	Hour	58	450.00	25.47	**664767.00**	
Multi Customer Nurse	☐	Hour	2	1748.00	47.28	**165290.88**	
RN Independant	☐	Hour	43	400.00	35.12	**604064.00**	
LPN Independant	☐	Hour	60	1100.00	27.15	**1791900.00**	
RN Agency Capitated	☑	Hour	42	154.00	7.67	**49609.56**	
LPN Agency Capitated	☑	Hour	15	538.00	33.27	**268488.90**	
Multi Customer Nurse Capitated	☑	Hour	1	1.00	51.96	**51.96**	
RN Independant Capitated	☑	Hour	6	774.00	35.20	**163468.80**	
LPN Independant Capitated	☑	Hour	10	849.00	27.21	**231012.90**	
RN Agency MMAI	☑	Hour	3	391.00	35.02	**41078.46**	
LPN Agency MMAI	☑	Hour	5	338.00	27.94	**47218.60**	
Multi Customer Nurse MMAI	☑	Hour	2	1.00	51.86	**103.72**	
RN Independant MMAI	☑	Hour	5	142.00	35.13	**24942.30**	
LPN Independant MMAI	☑	Hour	6	546.00	27.16	**88976.16**	
RN Agency MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
LPN Agency MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
Multi Customer Nurse MMAI Opt	☑	Hour	1	1.00	0.01	**0.01**	

Out							
RN Independant MMAI Opt Out	☐	Hour	1	1.00	0.01	**0.01**	
LPN Independant MMAI Opt Out	☐	Hour	1	1.00	0.01	**0.01**	
Intermittent Nursing Total:							**1076372.61**
Intermittent Nursing	☐	Hour	160	33.00	65.25	**344520.00**	
Intermittent Nursing Capitated	☑	Hour	806	10.00	84.94	**684616.40**	
Intermittent Nursing MMAI	☑	Hour	20	33.00	71.57	**47236.20**	
Intermittent Nursing MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
Personal Emergency Response System Total:							**1178459.36**
Personal Emergency Response	☐	One time	3692	9.00	28.00	**930384.00**	
Personal Emergency Response Install	☐	Month	350	1.00	30.00	**10500.00**	
Personal Emergency Response Capitated	☑	Month	428	9.00	30.77	**118526.04**	
Personal Emergency Response Install Capitated	☑	One time	60	1.00	32.97	**1978.20**	
Personal Emergency Response MMAI	☑	One time	420	9.00	30.71	**116083.80**	
Personal Emergency Response Install MMAI	☑	Month	30	1.00	32.91	**987.30**	
Personal Emergency Response MMAI Opt Out	☑	One time	1	1.00	0.01	**0.01**	
Personal Emergency Response Install MMAI Opt Out	☑	Month	1	1.00	0.01	**0.01**	
Specialized Medical Equipment Total:							**1442432.70**
Specialized Medical Equipment	☐	Unit	156	1.30	1225.00	**248430.00**	
Specialized Medical Equipment Capitated	☑	Unit	31	1.00	37779.37	**1171160.47**	
Specialized Medical Equipment MMAI	☑	Unit	17	1.00	1343.66	**22842.22**	
Specialized Medical Equipment MMAI Opt Out	☑	Unit	1	1.00	0.01	**0.01**	
					GRAND TOTAL:		**536606220.99**
					Total: Services included in capitation:		114953960.09
					Total: Services not included in capitation:		421652260.90

Total Estimated Unduplicated Participants:	**34993**
Factor D (Divide total by number of participants):	**15334.67**
Services included in capitation:	3285.06
Services not included in capitation:	12049.62
Average Length of Stay on the Waiver:	292

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**2234690.68**
Adult Day Care	☐	Day	172	959.00	9.02	**1487830.96**	
Adult Day Care Transport	☐	Day	130	205.00	8.30	**221195.00**	
Adult Day Care Capitated	☑	Day	30	861.00	10.11	**261141.30**	
Adult Day Care Transport Capitated	☑	Day	66	72.00	6.60	**31363.20**	
Adult Day Care MMAI	☑	Day	23	827.00	10.09	**191921.89**	
Adult Day Care Transport MMAI	☑	Day	23	193.00	9.29	**41238.31**	
Adult Day Care MMAI Opt Out	☑	Day	1	1.00	0.01	**0.01**	
Adult Day Care Transport Opt Out	☑	Day	1	1.00	0.01	**0.01**	
Homemaker Total:							**51308037.67**
HomeMaker	☐	Hour	3126	685.00	17.14	**36702053.40**	
HomeMaker Capitated	☑	Hour	616	741.00	21.51	**9818368.56**	
HomeMaker MMAI	☑	Hour	387	645.00	19.18	**4787615.70**	
HomeMaker MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
Individual Provider (Personal Assistant - Non Agency) Total:							**484713821.29**
Personal Assistant	☐	Hour	20048	1327.76	14.44	**384377385.01**	
Personal Assistant Capitated	☑	Hour	3689	1093.00	15.67	**63182646.59**	
Personal							

Assistant MMAI	✓	Hour	2082	1141.00	15.64	**37153789.68**	
Personal Assistant MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Respite Total:							**1040679.56**
RN		Hour	6	60.00	33.35	**12006.00**	
LPN		Hour	12	120.00	28.75	**41400.00**	
HomeMaker		Hour	23	145.00	17.14	**57161.90**	
Personal Assistant		Hour	310	175.00	14.43	**782827.50**	
Home Health Aide (CNA)		Hour	10	220.00	15.52	**34144.00**	
Adult Day Care		Day	1	5.00	9.00	**45.00**	
Adult Day Care Transport		Day	1	5.00	8.30	**41.50**	
RN Capitated	✓	Hour	1	18.00	33.13	**596.34**	
LPN Capitated	✓	Hour	1	46.00	28.55	**1313.30**	
HomeMaker Capitated	✓	Hour	4	190.00	19.21	**14599.60**	
Personal Assistant Capitated	✓	Hour	20	175.00	15.67	**54845.00**	
Home Health Aide (CNA) Capitated	✓	Hour	2	224.00	15.41	**6903.68**	
Adult Day Care Capitated	✓	Day	1	5.00	10.09	**50.45**	
Adult Day Care Transport Capitated	✓	Day	1	5.00	9.30	**46.50**	
RN MMAI	✓	Hour	2	15.00	33.06	**991.80**	
LPN MMAI	✓	Hour	2	86.00	28.50	**4902.00**	
HomeMaker MMAI	✓	Hour	2	78.00	19.18	**2992.08**	
Personal Assistant MMAI	✓	Hour	6	175.00	15.64	**16422.00**	
Home Health Aide (CNA) MMAI	✓	Hour	2	299.00	15.38	**9197.24**	
Adult Day Care MMAI	✓	Day	2	5.00	10.07	**100.70**	
Adult Day Care Transport MMAI	✓	Day	2	5.00	9.29	**92.90**	
RN MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
LPN MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
HomeMaker MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Personal Assistant MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Home Health Aide (CNA) MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	

Adult Day Care MMAI Opt Out	✓	Day	1	1.00	0.01	**0.01**	
Adult Day Care Transport MMAI Opt Out	✓	Day	1	1.00	0.01	**0.01**	
Home Health Aide Total:							**5467681.25**
Home Health Aide Agency(CNA)		Hour	224	614.73	13.75	**1893368.40**	
Home Health Aide Independant (CNA)		Hour	153	821.28	19.43	**2441492.97**	
Home Health Aide Agency Capitated	✓	Hour	38	555.00	16.08	**339127.20**	
Home Health Aide Agency MMAI	✓	Hour	23	449.00	15.38	**158829.26**	
Home Health Aide Agency MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Home Health Aide Independant Capitated	✓	Hour	50	330.00	19.30	**318450.00**	
Home Health Aide Independant MMAI	✓	Hour	20	821.00	19.27	**316413.40**	
Home Health Aide Independant MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Occupational Therapy Total:							**42908.25**
Occupational Therapy		Hour	3	10.00	53.00	**1590.00**	
Occupational Therapy Capitated	✓	Hour	154	4.00	66.69	**41081.04**	
Occupational Therapy MMAI	✓	Hour	2	2.00	59.30	**237.20**	
Occupational Therapy MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Physical Therapy Total:							**105091.96**
Physical Therapy		Hour	2	26.00	53.00	**2756.00**	
Physical Therapy Capitated	✓	Hour	305	5.00	66.95	**102098.75**	
Physical Therapy MMAI	✓	Hour	2	2.00	59.30	**237.20**	
Physical Therapy MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Speech Therapy Total:							**1983.65**
Speech Therapy		Hour	1	10.00	53.00	**530.00**	
Speech Therapy Capitated	✓	Hour	1	4.00	66.91	**267.64**	
Speech Therapy MMAI	✓	Hour	2	10.00	59.30	**1186.00**	
Speech Therapy MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Environmental Accessibility							**739475.26**

Adaptations Total:							
Environmental Accessibility Adaptations	☐	Unit	88	1.00	6500.00	**572000.00**	
Environmental Accessibility Adaptations Capitated	☑	Unit	15	1.00	7286.51	**109297.65**	
Environmental Accessibility Adaptations MMAI	☑	Hour	8	1.00	7272.20	**58177.60**	
Environmental Accessibility Adaptations MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
Home Delivered Meals Total:							**4985115.21**
Home Delivered Meals	☐	Day/week	1103	246.00	15.00	**4070070.00**	
Home Delivered Meals Capitated	☑	Day/week	205	232.00	13.07	**621609.20**	
Home Delivered Meals MMAI	☑	Day/week	135	208.00	10.45	**293436.00**	
Home Delivered Meals MMAI Opt Out	☑	Day/week	1	1.00	0.01	**0.01**	
In-Home Shift Nursing Total:							**4840681.21**
RN Agency	☐	Hour	40	506.61	29.55	**598813.02**	
LPN Agency	☐	Hour	59	450.00	25.47	**676228.50**	
Multi Customer Nurse	☐	Hour	2	1748.00	47.28	**165290.88**	
RN Independant	☐	Hour	43	400.00	36.15	**621780.00**	
LPN Independant	☐	Hour	60	1100.00	27.94	**1844040.00**	
RN Agency Capitated	☑	Hour	43	154.00	7.83	**51850.26**	
LPN Agency Capitated	☑	Hour	15	538.00	33.93	**273815.10**	
Multi Customer Nurse Capitated	☑	Hour	1	1.00	53.00	**53.00**	
RN Independant Capitated	☑	Hour	6	774.00	35.91	**166766.04**	
LPN Independant Capitated	☑	Hour	10	849.00	27.76	**235682.40**	
RN Agency MMAI	☑	Hour	3	391.00	35.72	**41899.56**	
LPN Agency MMAI	☑	Hour	5	338.00	28.50	**48165.00**	
Multi Customer Nurse MMAI	☑	Hour	2	1.00	52.90	**105.80**	
RN Independant MMAI	☑	Hour	5	142.00	35.84	**25446.40**	
LPN Independant MMAI	☑	Hour	6	546.00	27.70	**90745.20**	
RN Agency MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
LPN Agency MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	

Multi Customer Nurse MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
RN Independant MMAI Opt Out		Hour	1	1.00	0.01	**0.01**	
LPN Independant MMAI Opt Out		Hour	1	1.00	0.01	**0.01**	
Intermittent Nursing Total:							**1114221.01**
Intermittent Nursing		Hour	160	33.00	65.25	**344520.00**	
Intermittent Nursing Capitated	✓	Hour	830	10.00	86.64	**719112.00**	
Intermittent Nursing MMAI	✓	Hour	21	33.00	73.00	**50589.00**	
Intermittent Nursing MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Personal Emergency Response System Total:							**1196353.24**
Personal Emergency Response		One time	3710	9.00	28.00	**934920.00**	
Personal Emergency Response Install		Month	350	1.00	30.00	**10500.00**	
Personal Emergency Response Capitated	✓	Month	441	9.00	31.39	**124586.91**	
Personal Emergency Response Install Capitated	✓	One time	62	1.00	33.63	**2085.06**	
Personal Emergency Response MMAI	✓	One time	437	9.00	31.33	**123220.89**	
Personal Emergency Response Install MMAI	✓	Month	31	1.00	33.56	**1040.36**	
Personal Emergency Response MMAI Opt Out	✓	One time	1	1.00	0.01	**0.01**	
Personal Emergency Response Install MMAI Opt Out	✓	Month	1	1.00	0.01	**0.01**	
Specialized Medical Equipment Total:							**396457.95**
Specialized Medical Equipment		Unit	156	1.30	1225.00	**248430.00**	
Specialized Medical Equipment Capitated	✓	Unit	32	1.00	3854.95	**123358.40**	
Specialized Medical Equipment MMAI	✓	Unit	18	1.00	1370.53	**24669.54**	
Specialized Medical Equipment MMAI Opt Out	✓	Unit	1	1.00	0.01	**0.01**	
				GRAND TOTAL:			**558187198.19**

Total: Services included in capitation:	120044778.13
Total: Services not included in capitation:	438142420.06
Total Estimated Unduplicated Participants:	**36068**
Factor D (Divide total by number of participants):	**15475.97**
Services included in capitation:	3328.29
Services not included in capitation:	12147.68
Average Length of Stay on the Waiver:	292

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**2309291.71**
Adult Day Care	☐	Day	174	976.00	9.02	**1531812.48**	
Adult Day Care Transport	☐	Day	130	205.00	8.30	**221195.00**	
Adult Day Care Capitated	☑	Day	31	861.00	10.31	**275184.21**	
Adult Day Care Transport Capitated	☑	Day	68	72.00	6.74	**32999.04**	
Adult Day Care MMAI	☑	Day	24	827.00	10.29	**204235.92**	
Adult Day Care Transport MMAI	☑	Day	24	193.00	9.47	**43865.04**	
Adult Day Care MMAI Opt Out	☑	Day	1	1.00	0.01	**0.01**	
Adult Day Care Transport Opt Out	☑	Day	1	1.00	0.01	**0.01**	
Homemaker Total:							**52057564.37**
HomeMaker	☐	Hour	3124	685.00	17.14	**36678571.60**	
HomeMaker Capitated	☑	Hour	634	741.00	21.94	**10307280.36**	
HomeMaker MMAI	☑	Hour	402	645.00	19.56	**5071712.40**	
HomeMaker MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
Individual Provider (Personal Assistant - Non Agency) Total:							**504037968.27**
Personal Assistant	☐	Hour	20409	1351.26	14.44	**398224375.51**	
Personal						**66412866.00**	

Assistant Capitated	✓	Hour	3800	1093.00	15.99		
Personal Assistant MMAI	✓	Hour	2165	1141.00	15.95	**39400726.75**	
Personal Assistant MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Respite Total:							**1045764.94**
RN		Hour	6	60.00	33.35	**12006.00**	
LPN		Hour	12	120.00	28.75	**41400.00**	
HomeMaker		Hour	23	145.00	17.14	**57161.90**	
Personal Assistant		Hour	310	175.00	14.43	**782827.50**	
Home Health Aide (CNA)		Hour	10	220.00	15.52	**34144.00**	
Adult Day Care		Day	1	5.00	9.00	**45.00**	
Adult Day Care Transport		Day	1	5.00	8.30	**41.50**	
RN Capitated	✓	Hour	1	18.00	33.79	**608.22**	
LPN Capitated	✓	Hour	1	46.00	29.12	**1339.52**	
HomeMaker Capitated	✓	Hour	4	190.00	19.60	**14896.00**	
Personal Assistant Capitated	✓	Hour	21	175.00	15.99	**58763.25**	
Home Health Aide (CNA) Capitated	✓	Hour	2	224.00	15.72	**7042.56**	
Adult Day Care Capitated	✓	Day	1	5.00	10.29	**51.45**	
Adult Day Care Transport Capitated	✓	Day	1	5.00	9.49	**47.45**	
RN MMAI	✓	Hour	2	15.00	33.72	**1011.60**	
LPN MMAI	✓	Hour	2	86.00	29.07	**5000.04**	
HomeMaker MMAI	✓	Hour	2	78.00	19.56	**3051.36**	
Personal Assistant MMAI	✓	Hour	6	175.00	15.95	**16747.50**	
Home Health Aide (CNA) MMAI	✓	Hour	2	299.00	15.69	**9382.62**	
Adult Day Care MMAI	✓	Day	2	5.00	10.27	**102.70**	
Adult Day Care Transport MMAI	✓	Day	2	5.00	9.47	**94.70**	
RN MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
LPN MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
HomeMaker MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Personal Assistant MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Home Health							

Aide (CNA) MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Adult Day Care MMAI Opt Out	✓	Day	1	1.00	0.01	**0.01**	
Adult Day Care Transport MMAI Opt Out	✓	Day	1	1.00	0.01	**0.01**	
Home Health Aide Total:							**5639106.97**
Home Health Aide Agency(CNA)		Hour	229	636.25	13.75	**2003392.19**	
Home Health Aide Independant (CNA)		Hour	153	821.28	19.43	**2441492.97**	
Home Health Aide Agency Capitated	✓	Hour	39	555.00	16.40	**354978.00**	
Home Health Aide Agency MMAI	✓	Hour	24	449.00	15.69	**169075.44**	
Home Health Aide Agency MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Home Health Aide Independant Capitated	✓	Hour	51	330.00	19.69	**331382.70**	
Home Health Aide Independant MMAI	✓	Hour	21	821.00	19.65	**338785.65**	
Home Health Aide Independant MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Occupational Therapy Total:							**45099.01**
Occupational Therapy		Hour	3	10.00	53.00	**1590.00**	
Occupational Therapy Capitated	✓	Hour	2	2.00	60.48	**241.92**	
Occupational Therapy MMAI	✓	Hour	159	4.00	68.03	**43267.08**	
Occupational Therapy MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Physical Therapy Total:							**110213.23**
Physical Therapy		Hour	2	26.00	53.00	**2756.00**	
Physical Therapy Capitated	✓	Hour	314	5.00	68.29	**107215.30**	
Physical Therapy MMAI	✓	Hour	2	2.00	60.48	**241.92**	
Physical Therapy MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Speech Therapy Total:							**1044.93**
Speech Therapy		Hour	1	10.00	53.00	**530.00**	
Speech Therapy Capitated	✓	Hour	1	4.00	68.25	**273.00**	
Speech Therapy MMAI	✓	Hour	2	2.00	60.48	**241.92**	
Speech Therapy MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	

Environmental Accessibility Adaptations Total:							**742824.73**
Environmental Accessibility Adaptations	☐	Unit	88	1.00	6500.00	**572000.00**	
Environmental Accessibility Adaptations Capitated	☑	Unit	15	1.00	7432.24	**111483.60**	
Environmental Accessibility Adaptations MMAI	☑	Hour	8	1.00	7417.64	**59341.12**	
Environmental Accessibility Adaptations MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
Home Delivered Meals Total:							**5046369.37**
Home Delivered Meals	☐	Day/week	1076	253.00	15.00	**4083420.00**	
Home Delivered Meals Capitated	☑	Day/week	211	232.00	13.33	**652530.16**	
Home Delivered Meals MMAI	☑	Day/week	140	208.00	10.66	**310419.20**	
Home Delivered Meals MMAI Opt Out	☑	Day/week	1	1.00	0.01	**0.01**	
In-Home Shift Nursing Total:							**4869854.73**
RN Agency	☐	Hour	40	506.00	29.55	**598092.00**	
LPN Agency	☐	Hour	60	450.00	25.47	**687690.00**	
Multi Customer Nurse	☐	Hour	2	1748.00	47.28	**165290.88**	
RN Independant	☐	Hour	43	400.00	36.15	**621780.00**	
LPN Independant	☐	Hour	60	1100.00	27.94	**1844040.00**	
RN Agency Capitated	☑	Hour	44	154.00	7.98	**54072.48**	
LPN Agency Capitated	☑	Hour	15	538.00	34.61	**279302.70**	
Multi Customer Nurse Capitated	☑	Hour	1	1.00	54.06	**54.06**	
RN Independant Capitated	☑	Hour	6	774.00	36.32	**168670.08**	
LPN Independant Capitated	☑	Hour	10	849.00	28.31	**240351.90**	
RN Agency MMAI	☑	Hour	3	391.00	36.44	**42744.12**	
LPN Agency MMAI	☑	Hour	5	338.00	29.07	**49128.30**	
Multi Customer Nurse MMAI	☑	Hour	2	1.00	53.95	**107.90**	
RN Independant MMAI	☑	Hour	5	142.00	36.55	**25950.50**	
LPN Independant MMAI	☑	Hour	6	546.00	28.26	**92579.76**	
RN Agency MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	

LPN Agency MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Multi Customer Nurse MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
RN Independant MMAI Opt Out		Hour	1	1.00	0.01	**0.01**	
LPN Independant MMAI Opt Out		Hour	1	1.00	0.01	**0.01**	
Intermittent Nursing Total:							**1154141.47**
Intermittent Nursing		Hour	160	33.00	65.25	**344520.00**	
Intermittent Nursing Capitated	✓	Hour	855	10.00	88.37	**755563.50**	
Intermittent Nursing MMAI	✓	Hour	22	33.00	74.46	**54057.96**	
Intermittent Nursing MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Personal Emergency Response System Total:							**1240345.50**
Personal Emergency Response		One time	3729	9.00	28.00	**939708.00**	
Personal Emergency Response Install		Month	350	1.00	30.00	**10500.00**	
Personal Emergency Response Capitated	✓	Month	454	9.00	32.02	**130833.72**	
Personal Emergency Response Install Capitated	✓	One time	64	1.00	34.30	**2195.20**	
Personal Emergency Response MMAI	✓	One time	454	9.00	31.95	**130547.70**	
Personal Emergency Response Install MMAI	✓	Month	19	1.00	1397.94	**26560.86**	
Personal Emergency Response MMAI Opt Out	✓	One time	1	1.00	0.01	**0.01**	
Personal Emergency Response Install MMAI Opt Out	✓	Month	1	1.00	0.01	**0.01**	
Specialized Medical Equipment Total:							**404748.52**
Specialized Medical Equipment		Unit	156	1.30	1225.00	**248430.00**	
Specialized Medical Equipment Capitated	✓	Unit	33	1.00	3932.05	**129757.65**	
Specialized Medical Equipment MMAI	✓	Unit	19	1.00	1397.94	**26560.86**	
Specialized Medical Equipment	✓	Unit	1	1.00	0.01	**0.01**	

MMAI Opt Out							

GRAND TOTAL:	**578704337.75**
Total: Services included in capitation:	126555525.20
Total: Services not included in capitation:	452148812.55
Total Estimated Unduplicated Participants:	**37177**
Factor D (Divide total by number of participants):	**15566.19**
Services included in capitation:	3404.13
Services not included in capitation:	12162.06
Average Length of Stay on the Waiver:	292

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**2385771.22**
Adult Day Care	☐	Day	176	993.00	9.02	**1576407.36**	
Adult Day Care Transport	☐	Day	130	205.00	8.30	**221195.00**	
Adult Day Care Capitated	☑	Day	32	861.00	10.52	**289847.04**	
Adult Day Care Transport Capitated	☑	Day	70	72.00	6.87	**34624.80**	
Adult Day Care MMAI	☑	Day	25	827.00	10.50	**217087.50**	
Adult Day Care Transport MMAI	☑	Day	25	193.00	9.66	**46609.50**	
Adult Day Care MMAI Opt Out	☑	Day	1	1.00	0.01	**0.01**	
Adult Day Care Transport Opt Out	☑	Day	1	1.00	0.01	**0.01**	
Homemaker Total:							**52862887.05**
HomeMaker	☐	Hour	3122	685.00	17.14	**36655089.80**	
HomeMaker Capitated	☑	Hour	653	741.00	22.38	**10829077.74**	
HomeMaker MMAI	☑	Hour	418	645.00	19.95	**5378719.50**	
HomeMaker MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
Individual Provider (Personal Assistant - Non Agency) Total:							**524077635.10**
Personal						**412558480.92**	

Assistant	☐	Hour	20776	1375.17	14.44		
Personal Assistant Capitated	☑	Hour	3914	1093.00	16.30	**69731432.60**	
Personal Assistant MMAI	☑	Hour	2251	1141.00	16.27	**41787721.57**	
Personal Assistant MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
Respite Total:							**1051486.53**
RN	☐	Hour	6	60.00	33.35	**12006.00**	
LPN	☐	Hour	12	120.00	28.75	**41400.00**	
HomeMaker	☐	Hour	23	145.00	17.14	**57161.90**	
Personal Assistant	☐	Hour	310	175.00	14.44	**783370.00**	
Home Health Aide (CNA)	☐	Hour	10	220.00	15.52	**34144.00**	
Adult Day Care	☐	Day	1	5.00	9.00	**45.00**	
Adult Day Care Transport	☐	Day	1	5.00	8.30	**41.50**	
RN Capitated	☑	Hour	1	18.00	34.46	**620.28**	
LPN Capitated	☑	Hour	1	46.00	29.71	**1366.66**	
HomeMaker Capitated	☑	Hour	4	190.00	19.99	**15192.40**	
Personal Assistant Capitated	☑	Hour	22	175.00	16.30	**62755.00**	
Home Health Aide (CNA) Capitated	☑	Hour	2	224.00	16.04	**7185.92**	
Adult Day Care Capitated	☑	Day	1	5.00	10.50	**52.50**	
Adult Day Care Transport Capitated	☑	Day	1	5.00	9.68	**48.40**	
RN MMAI	☑	Hour	2	15.00	34.40	**1032.00**	
LPN MMAI	☑	Hour	2	86.00	29.65	**5099.80**	
HomeMaker MMAI	☑	Hour	2	78.00	19.95	**3112.20**	
Personal Assistant MMAI	☑	Hour	6	175.00	16.27	**17083.50**	
Home Health Aide (CNA) MMAI	☑	Hour	2	299.00	16.00	**9568.00**	
Adult Day Care MMAI	☑	Day	2	5.00	10.48	**104.80**	
Adult Day Care Transport MMAI	☑	Day	2	5.00	9.66	**96.60**	
RN MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
LPN MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
HomeMaker MMAI Opt Out	☑	Hour	1	1.00	0.01	**0.01**	
Personal Assistant MMAI	☑	Hour	1	1.00	0.01	**0.01**	

Opt Out							
Home Health Aide (CNA) MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Adult Day Care MMAI Opt Out	✓	Day	1	1.00	0.01	**0.01**	
Adult Day Care Transport MMAI Opt Out	✓	Day	1	1.00	0.01	**0.01**	
Home Health Aide Total:							**5815394.12**
Home Health Aide Agency(CNA)		Hour	233	658.52	13.75	**2109733.45**	
Home Health Aide Independant (CNA)		Hour	153	821.28	19.43	**2441492.97**	
Home Health Aide Agency Capitated	✓	Hour	40	555.00	16.73	**371406.00**	
Home Health Aide Agency MMAI	✓	Hour	25	449.00	16.00	**179600.00**	
Home Health Aide Agency MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Home Health Aide Independant Capitated	✓	Hour	53	330.00	20.08	**351199.20**	
Home Health Aide Independant MMAI	✓	Hour	22	821.00	20.04	**361962.48**	
Home Health Aide Independant MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Occupational Therapy Total:							**47356.61**
Occupational Therapy		Hour	3	10.00	53.00	**1590.00**	
Occupational Therapy Capitated	✓	Hour	164	4.00	69.39	**45519.84**	
Occupational Therapy MMAI	✓	Hour	2	2.00	61.69	**246.76**	
Occupational Therapy MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Physical Therapy Total:							**115503.67**
Physical Therapy		Hour	2	26.00	53.00	**2756.00**	
Physical Therapy Capitated	✓	Hour	323	5.00	69.66	**112500.90**	
Physical Therapy MMAI	✓	Hour	2	2.00	61.69	**246.76**	
Physical Therapy MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Speech Therapy Total:							**1055.25**
Speech Therapy		Hour	1	10.00	53.00	**530.00**	
Speech Therapy Capitated	✓	Hour	1	4.00	69.62	**278.48**	
Speech Therapy MMAI	✓	Hour	2	2.00	61.69	**246.76**	

Speech Therapy MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Environmental Accessibility Adaptations Total:							**746241.28**
Environmental Accessibility Adaptations		Unit	88	1.00	6500.00	**572000.00**	
Environmental Accessibility Adaptations Capitated	✓	Unit	15	1.00	7580.89	**113713.35**	
Environmental Accessibility Adaptations MMAI	✓	Hour	8	1.00	7565.99	**60527.92**	
Environmental Accessibility Adaptations MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Home Delivered Meals Total:							**5105375.13**
Home Delivered Meals		Day/week	1049	260.00	15.00	**4091100.00**	
Home Delivered Meals Capitated	✓	Day/week	217	232.00	13.59	**684174.96**	
Home Delivered Meals MMAI	✓	Day/week	146	208.00	10.87	**330100.16**	
Home Delivered Meals MMAI Opt Out	✓	Day/week	1	1.00	0.01	**0.01**	
In-Home Shift Nursing Total:							**4903083.90**
RN Agency		Hour	40	506.00	29.55	**598092.00**	
LPN Agency		Hour	61	450.00	25.47	**699151.50**	
Multi Customer Nurse		Hour	2	1748.00	47.28	**165290.88**	
RN Independant		Hour	43	400.00	36.15	**621780.00**	
LPN Independant		Hour	60	1100.00	27.94	**1844040.00**	
RN Agency Capitated	✓	Hour	45	154.00	8.14	**56410.20**	
LPN Agency Capitated	✓	Hour	15	538.00	35.30	**284871.00**	
Multi Customer Nurse Capitated	✓	Hour	1	1.00	55.14	**55.14**	
RN Independant Capitated	✓	Hour	6	774.00	37.36	**173499.84**	
LPN Independant Capitated	✓	Hour	10	849.00	28.88	**245191.20**	
RN Agency MMAI	✓	Hour	3	391.00	37.17	**43600.41**	
LPN Agency MMAI	✓	Hour	5	338.00	29.65	**50108.50**	
Multi Customer Nurse MMAI	✓	Hour	2	1.00	55.03	**110.06**	
RN Independant MMAI	✓	Hour	5	142.00	37.28	**26468.80**	
LPN Independant MMAI	✓	Hour	6	546.00	28.82	**94414.32**	

RN Agency MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
LPN Agency MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Multi Customer Nurse MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
RN Independant MMAI Opt Out		Hour	1	1.00	0.01	**0.01**	
LPN Independant MMAI Opt Out		Hour	1	1.00	0.01	**0.01**	
Intermittent Nursing Total:							**1196299.46**
Intermittent Nursing		Hour	160	33.00	65.25	**344520.00**	
Intermittent Nursing Capitated	✓	Hour	881	10.00	90.14	**794133.40**	
Intermittent Nursing MMAI	✓	Hour	23	33.00	75.95	**57646.05**	
Intermittent Nursing MMAI Opt Out	✓	Hour	1	1.00	0.01	**0.01**	
Personal Emergency Response System Total:							**1234463.96**
Personal Emergency Response		One time	3748	9.00	28.00	**944496.00**	
Personal Emergency Response Install		Month	350	1.00	30.00	**10500.00**	
Personal Emergency Response Capitated	✓	Month	468	9.00	32.66	**137563.92**	
Personal Emergency Response Install Capitated	✓	One time	66	1.00	34.99	**2309.34**	
Personal Emergency Response MMAI	✓	One time	472	9.00	32.59	**138442.32**	
Personal Emergency Response Install MMAI	✓	Month	33	1.00	34.92	**1152.36**	
Personal Emergency Response MMAI Opt Out	✓	One time	1	1.00	0.01	**0.01**	
Personal Emergency Response Install MMAI Opt Out	✓	Month	1	1.00	0.01	**0.01**	
Specialized Medical Equipment Total:							**419681.47**
Specialized Medical Equipment		Unit	160	1.30	1225.00	**254800.00**	
Specialized Medical Equipment Capitated	✓	Unit	34	1.00	4010.69	**136363.46**	
Specialized Medical Equipment MMAI	✓	Unit	20	1.00	1425.90	**28518.00**	

Specialized Medical Equipment MMAI Opt Out	✓	Unit	1	1.00	0.01	**0.01**	

GRAND TOTAL:	**599962234.76**
Total: Services included in capitation:	133321020.45
Total: Services not included in capitation:	466641214.31
Total Estimated Unduplicated Participants:	**38320**
Factor D (Divide total by number of participants):	**15656.63**
Services included in capitation:	3479.15
Services not included in capitation:	12177.48
Average Length of Stay on the Waiver:	292