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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:
Persons with Disabilities

C. Waiver Number:IL.0142
Original Base Waiver Number: IL.0142.

D. Amendment Number:IL.0142.R05.03

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

03/01/14

Approved Effective Date: 03/01/14
Approved Effective Date of Waiver being Amended: 10/01/09

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
The Illinois Department of Healthcare and Family Services (HFS) is amending the current 1915 (c) waivers to include those participants whose waiver services will be administered under the Medicare Medicaid Alignment Initiative (MMAI) and under the 1915(b) Managed Long-term Supports and Services (MLTSS) waiver. The MMAI will be operating under Section 1932(a)(1)(A)(ii) of the Social Security Act. The proposed effective date for initial implementation is March 1, 2014 for the greater Chicago and Central Illinois regions. Beginning on March 1, 2014, participants will be able to voluntarily enroll in MMAI. Passive enrollment will begin June 1, 2014.

HFS will also be submitting a concurrent 1915b/c waiver (MLTSS waiver) to mandatorily enroll into managed care the dual population receiving Long-term Supports and Services (LTSS) that opt-out of the MMAI. For those participants that wish to opt-out of the MMAI and are receiving LTSS, HFS will provide LTSS, behavioral health (mental health and substance abuse) and transportation services, using the same Health Plans chosen for MMAI. The difference is that these participants will not have their Medicare covered services covered or coordinated by the Health Plans. For those that opt-out of MMAI and are not receiving LTSS, those participants will receive their Medicaid services via fee-for-service.

Background on the Integrated Medicare Medicaid Alignment Initiative (MMAI)

On February 22, 2013, HFS received approval from the federal Centers for Medicare and Medicaid Services (CMS) to jointly implement the MMAI. The MMAI is a groundbreaking joint effort to reform the way care is delivered to clients eligible for both Medicare and Medicaid Services (called "dual eligibles"). The MMAI demonstration project will provide coordinated care to more than 135,000 Medicare-Medicaid enrollees in the Chicagoland area, including Cook, DuPage, Kane, Kankakee, Lake and Will counties, as well as throughout central Illinois, including Champaign, Christian, Dewitt, Ford, Knox, Logan, Macon, McLean, Menard, Peoria, Piatt, Sangamon, Stark, Tazewell and Vermillion counties. Under the MMAI, Illinois and CMS will contract with Health Plans to coordinate the delivery of and be accountable for all covered Medicare and Medicaid services for participating Medicare-Medicaid enrollees. This includes HCBS waiver services. Eight Managed Care Organizations (Plans) were chosen by HFS for MMAI. Participants will have the choice of six Plans in the greater Chicago region and two Plans in the Central Illinois region.

Prior to choosing a Plan, HFS will provide a choice to all potential enrollees for the participation in the MMAI demonstration. This program will be operated under a 1932a State Plan Authority, operated under IL.13-015. HFS realizes that not all potential enrollees will choose this program; therefore HFS will have a separate program for those that opt-out and are receiving LTSS (MLTSS waiver). This program will not include Medicare covered services, but will include Medicaid covered long term support services (nursing homes and waiver services), transportation and behavioral health services. For those that opt-out of the MMAI demonstration and are receiving LTSS, enrollment with a Health Plan will be mandatory in order to receive Medicaid LTSS, transportation, and behavioral health services. The Plans will coordinate care for all participants enrolled in MMAI or the MLTSS 1915(b) waiver. The only difference is that for those that opt out, the Plans will not be responsible for the Medicare-only services.

Waiver and Other Assurances:

HFS, as the Medicaid Agency (MA) will continue to meet federal Centers for Medicare and Medicaid Services (CMS) assurances required under the waiver. HCBS waiver eligibility determinations will continue to be conducted by separate entities, contracted by the State, just as they are done today. Information specific to the 1915c waiver oversight responsibilities follows.

Eligibility

Waiver eligibility determination and redetermination criteria will remain the same as in the existing waiver and will be the same for all waiver participants, including those being served by the Plans.

Case Management

Case management, also known as care coordination, for participants in the waiver will be the responsibility of the Plans. Plans bring resources to the programs that will more effectively coordinate community based supports and services with physical health and other state plan services to meet the needs of the whole participant enrolled in MMAI or the MLTSS waiver. The Plans have the staffing and information technology resources to connect and share information from the many providers that serve participants. These resources will enhance oversight and monitoring of the provision of services and assurances that needs are being met.

Service Delivery - Provider Qualifications

The same approved waiver services are available through the Plans. Service delivery will remain the responsibility of the qualified waiver providers. Plans will recruit providers and, in the first year of the MMAI and MLTSS waiver, are required to contract with any willing and qualified providers currently approved to provide waiver services. Plans are required to maintain a network with a set of providers that provided at least eighty percent (80%) of the FFS services during calendar year (CY) 2012 and offer a choice of at least two providers (except for Personal Emergency Response Systems, Personal Assistants and Environmental Adaptations). Methods for determining provider qualifications for waiver services remain the same as described in the existing waiver. The Plans will be responsible to ensure that providers are qualified and enrolled.

Service Plan Development

The Plans will be responsible for service planning for participants enrolled in a Plan, including the development, implementation, monitoring, and updating of the plan when a participant's needs change. The Plan care coordinator will lead waiver service planning. In all aspects of service planning, the participant is the key member of the service planning team. The State will ensure that service plan development is conducted in the best interest of the participant and will be based on individual preferences and assessed needs.

Transition of service plans

In order to provide a more seamless transition, for participants who are enrolled in the existing waiver, the Plans will maintain the current service plans for at least 180-days, unless changed with the consent and input of the participants, and only after completion of a health screening and comprehensive needs assessment. Service plans will be transmitted from the Operating Agency (OA) to the Plans prior to the effective date. Eligibility reassessments that come due during this 180-day transition will be conducted by the OA as described in the existing waiver.

Health Safety and Welfare Roles and Responsibilities

The health, safety and welfare of the waiver participants who are enrolled in the Plans will be the responsibility of the Plans. This will include monitoring the participant to assure needs are being met, assuring providers are qualified, and reporting and following up on critical incidents. The Plans will have established processes and procedures in place to monitor access, quality, and appropriateness of service issues. Critical events and incidents must be reported and identified issues routed to the appropriate department within the Plans, to the Medicaid Agency (MA) and when indicated to the investigating authority described in Appendix G of the application. The procedures will include processes for ensuring participant safety while the State authority conducts its investigation. The Plans will review all incidents to identify trends and patterns and to determine whether individual or systemic changes are needed. The MA will oversee Plans to assure compliance with federal waiver requirements and ensure participants' needs are being met.

Participant Direction

Participant direction is integral to the design of the Illinois disability waivers. The MA will require that Plans allow participants, who elect to and can safely direct their own services, the opportunity and supports needed. Opportunities for participant direction, and the services available, will at minimum remain the same as described in the existing waiver. 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. The State will monitor Plans to ensure effective implementation of participant direction including through the use of participant satisfaction surveys.

Financial Management Services (FMS) will continue to be provided by the OA through a payroll system for independent providers including those designated as participant directed in Appendices C. and E of the application.

Quality Improvement Strategy

For participants enrolled in an MCO, the QIS will be reviewed and modified to assure that the Plans are complying with the waiver assurances in all delegated areas. For example, the Plans will primarily be responsible for care coordination, service plan development and implementation, prior authorization of waiver services, utilization management, qualified provider enrollment, health, safety, and welfare and quality assurance and quality improvement activities. Participants enrolled in MCOs will be included in the overall representative sampling methodology. The MA will monitor performance of the Plans through receipt and analysis of reported data, onsite visits, desk audits and interviews. The Plans will submit performance data at least quarterly, and more often as indicated by the contract. The MA will schedule onsite reviews and desk audits throughout the waiver year for the representative sample and validation reviews. The MA will meet quarterly with the Plans to identify and analyze trends based on scope, severity, changes and opportunities for system improvement.

In addition to waiver assurances, HFS will ensure compliance with implementation of the American Recovery and Reinvestment Act requirements for Indians, to include:

• HFS shall notify the Plans which Providers have been designated as Indian Health Care Providers.

• The Plans shall notify American Indian Enrollees upon enrollment, and annually thereafter, of their right to receive services at an Indian Health Care Provider.

• The Plans shall reimburse an Indian Health Provider at least the full encounter rate for fee-for-service rate established by the Department for that Provider, regardless of whether the Provider is an Affiliated Provider.

• The Plans shall not impose any co-payment on Enrollees identified as American Indian for a Covered Service received from an Indian Health Care Provider or any Medicaid Provider.

• The Plans shall not impose cost sharing on Enrollees identified as American Indian if the Enrollees have ever received services from an Indian Health Care Provider.

• An Enrollee identified as an American Indian is exempt from all cost sharing if the Enrollee has ever received a Referral from an Indian Tribe, Tribal Organization or Urban Indian Organization (I/T/U).

• The Plans shall not limit an Enrollee identified as an American Indian to I/T/U in the State of Illinois.

• HFS does not and will not waive the requirement that payments are consistent with efficiency, economy and quality.

• The Plans' contracts are compliant with the federal regulations that the managed care entities make prompt payment to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR sections 447.45 and 447.46.
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3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☑ **Waiver Application**	Main, 1, 2
☑ **Appendix A – Waiver Administration and Operation**	3
☐ **Appendix B – Participant Access and Eligibility**	
☐ **Appendix C – Participant Services**	
☑ **Appendix D – Participant Centered Service Planning and Delivery**	1.d
☑ **Appendix E – Participant Direction of Services**	1.j, 1.m
☐ **Appendix F – Participant Rights**	
☐ **Appendix G – Participant Safeguards**	
☐ **Appendix H**	
☑ **Appendix I – Financial Accountability**	3.g.iii
☑ **Appendix J – Cost-Neutrality Demonstration**	2

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

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

Specify:
Revise the delivery system to expand care coordination and waiver services delivery system to include those participants whose waiver services will be administered under the Medicare Medicaid Alignment Initiative (MMAI) for the dual eligible. For those who voluntarily enroll for MMAI, both Medicare and Medicaid covered services will be covered and coordinated by the Health Plans. For those who are dual eligible, but opt not to

participate in MMAI, the MA will administer and provide waiver and other Medicaid covered services under a concurrent 1915b/c waiver. This Managed Long-term Supports and Services (MLTSS) will use the same Health Plans chosen to provide MMAI. Services are designed in the similar manner as the Integrated Care Program.

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: amendment

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: IL.0142
Waiver Number:IL.0142.R05.03
Draft ID: IL.018.05.04

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/09
Approved Effective Date of Waiver being Amended: 10/01/09

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:

The State is submitting a concurrent 1915(b) waiver (1915(b) MLTSS waiver) at the same time as this 1915 (c) waiver amendment. The 1915(b) MLTSS waiver will allow the State to mandatorily enroll into managed care the dual population receiving Long-term Support Services (LTSS) who opt-out of the Medicare Medicaid Alignment Initiative (MMAI) described below, which is under 1932(a) authority of the Social Security Act. For those participants who wish to opt-out of the MMAI and are receiving LTSS, the State will provide LTSS and other Medicaid covered State Plan services, using the same managed care Health Plans chosen for MMAI. These participants will not have their Medicare covered services covered or coordinated by the Health Plans. For those who opt-out of the MMAI demonstration and are receiving LTSS, enrollment with a Health Plan will be mandatory in order to receive Medicaid LTSS, transportation, and specific behavioral health services.

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 Indians, except for voluntary enrollment as indicated in D.2.ii of the SPA.

Effective March 1, 2014, waiver services will be administered under the Medicare Medicaid Alignment Initiative (MMAI) for dually enrolled Medicare-Medicaid participants. Under the MMAI, Illinois and CMS will contract 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 will provide 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 is for the greater Chicago and Central Illinois regions where participants will be able to voluntarily enroll in MMAI. Passive enrollment will begin June 1, 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 will operate 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 HCBS waiver is part of a larger program called the Home Services Program (HSP). To be eligible, persons must meet a minimum score as determined by a standardized assessment of mental status, activities of daily living, and independent activities of daily living. 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.

HSP is operated under a state entitlement created as a result of a judicial decision emerging from the McMillan vs. McCrimon case in 1993. Individuals covered under the HCBS waiver are Medicaid eligible. However, 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. However, persons must meet Medicaid eligibility to participate in the HCBS waiver.

HSP is a consumer-directed program where most beneficiaries 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 and to fully and meaningfully participate as members of society. DHS is the fiscal agent with responsibility for issuing checks to workers, as well as withholding FICA and other deductions for consumer-directed workers.

DHS-DRS works closely with the Illinois Centers for Independent Living (CILs), which are staffed by persons with disabilities, per Title VII of the Rehabilitation Act. There are twenty-four CILs that recruit and train personal assistants and provide training to customers on how to manage workers. CILs are not only customer advocates, but lobby for policy and legislative changes that enhance the quality of life for all persons with disabilities.

There are 43 DHS HSP offices within the Division of Rehabilitation Services, that are staffed with HSP rehabilitation counselors that directly oversee the care provided to persons with disabilities under this program. The counselors are state employees.

In addition, a separate branch of DHS, the Division of Human Capitol Development maintains Family and Community Resource Centers. Medicaid eligibility is determined at these centers through a separate interagency agreement between DHS and HFS.

The HSP offers a full array of services which include: personal assistants, homemaker,skilled professional nursing, certified nursing assistants, therapies, adult day care, emergency home response, respite, home delivered meals, environmental modifications, and special medical equipment and supplies.

Effective February 1, 2013, the State will deliver care coordination and waiver services through a mandatory managed care delivery system for those waiver participants enrolled in the Integrated Care Program (ICP). The ICP is implemented in the Illinois areas of suburban Cook (all zip codes that do not begin with 606), DuPage, Kane, Kankakee, Lake and Will Counties. Future areas/MCO plans will affect the population similarly.

Effective March 1, 2014, the State will include dually enrolled Medicare and Medicaid waiver participants to the managed care delivery system. Waiver services will be administered under the Medicare Medicaid Alignment Initiative (MMAI) or the Managed Long-term Supports and Services (MLTSS) through a concurrent 1915(b) waiver. Under the MMAI, Illinois and CMS will contract 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. Initial implementation for the MMAI is for the greater Chicago and Central Illinois regions.

3. Components of the Waiver Request

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

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

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

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

E. **Free Choice of Provider**. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the

number of providers under the provisions of §1915(b) or another provision of the Act.

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

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

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

I. **Public Input.** Describe how the State secures public input into the development of the waiver:
DRS offers a variety of opportunities for public input into waiver activities including:

Customer Satisfaction Surveys
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.

HSP Stakeholder Meetings
As a new initiative, HSP began conducting bi-annual stakeholder meetings. The first meeting was held in January 2009. The purpose of these meetings is to seek direction from advocates regarding issues concerning the program, and to solicit on-going feedback to enhance service delivery and promote quality assurance. Through involvement of community stakeholders, HSP will be better equipped to assure that the program will fully meet the home care needs of persons with disabilities in Illinois.

Statewide Independent Living Council of Illinois
The Statewide Independent Living Council meets on a quarterly basis to address the independent living needs of persons with disabilities in Illinois. The Council is apprised of any changes and enhancements to the program and makes an annual report with recommendations or comments as appropriate. In 2008, SILC gave its full support of the Home Services by recommending continued state funding, and continued to offer its support of the HSP independent living model of consumer control.

Centers for Independent Living – Community Reintegration Project
The Home Services Program's Community Reintegration Project dramatically increases the quality of life of individuals served by this program. This program promotes independent living values including customer choice, personal independence, and integration and participation in the community. Case management for this program is handled by all twenty-three Centers for Independent Living (CIL) throughout the state. This ensures that this program is available at all counties in the state. Each CIL not only participates in the assessment and planning for customers participating in this project, but also is afforded the opportunity to participate in program enhancement activities with HSP administration.

American Indian Health Service of Chicago, Inc:

The American Indian Health Service of Chicago, Inc. was officially notified on March 30, 2009 that Illinois Healthcare and Family Services (HFS) would be renewing its Medicaid Home and Community Based Waiver for persons with disabilities and that the waiver application would be submitted to Federal CMS for approval in approximately 60 days. They were given the opportunity to ask questions or review the application.

On 10/16/12, the State shared the tribal government notifications and response with federal CMS. This included a 10/15/12 response from the tribal government indicating that their questions had been addressed. The original notice was issued on 07/26/12 and again on 9/19 and 9/26.

For the rate methodology amendment to be effective 07/01/13, the State notified the American Indian Health Service of Chicago, Inc. on 4/29/13. The State did not receive a response by 5/30/13, therefore a reminder notice was sent on that date. On 5/31, a response was received and there were no recommendations.

Integrated Care Program: In compliance with the CFR 438.50(b)(4), the State researched various integrated care models through literature and reaching out to other state Medicaid programs. The state held many meetings with clients, client advocates and providers to assist with the development of the program, development of the RFP to solicit the contractors, and to guide the implementation of the program. The list of represented entities included as invitees and attendees in found under B.4 of the approved 1932 a) SPA. The State will continue to have meetings with representatives from the above listed entities throughout implementation and on an on-going basis. These meetings will be through ad-hoc requests and regularly scheduled stakeholders meetings. Public input for future MCOs will be modeled in the same fashion.

Medicare Medicaid Alignment Initiative (MMAI)

The State held the first MMAI stakeholder webinar/meeting on April 18, 2013. Over 100 questions from that session were submitted to HFS during the webinar. Answers were posted on June 14, 2013 and can be found on the HFS Medicare-Medicaid Alignment Initiative webpage. Additional stakeholder meetings are being scheduled and will be held regularly.

HFS has maintained email accounts for receiving questions from the public about ICP since December 2012 and the MMAI since April 2013. HFS reads the emails daily and responds individually by phone or email.

The email addresses are: HFSCareCoor@illinois.gov and HFSMMAI@illinois.gov

The State issued the tribal government notifications about MMAI on April 29, 2013.

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

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

7. Contact Person(s)

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

Last Name: Bennett

First Name: Paul

Title: Acting Waiver Operations Manager, Bureau of Long Term Care

Agency: Department of Healthcare and Family Services

Address: 401 S. Clinton, 4th Floor

Address 2:

City: Chicago

State: **Illinois**

Zip: 60607

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

Fax: (312) 793-5278

E-mail: Paul.Bennett@Illinois.gov

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

Last Name: Sazone

First Name: Ron

Title: Acting Chief, Home Services Program

Agency: Department of Human Services, Division of Rehabilitation Services

Address: 400 West Lawrence

Address 2:

City: Springfield

State: **Illinois**

Zip: 62704

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

Fax: (217) 557-0142

E-mail: Ron.Sazone@illinois.gov

8. Authorizing Signature

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

Signature: Kelly Cunningham

State Medicaid Director or Designee

Submission Date: Feb 4, 2014

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

Last Name: Eagleson

First Name: Theresa

Title: Medicaid Director

Agency: Department of Healthcare and Family Services

Address: 201 South Grand Avenue East

Address 2:

City: Springfield

State: **Illinois**

Zip: 62763

Phone: (217) 785-3358 **Ext:** ☐ ☐ **TTY**

Fax: (217) 785-4477

E-mail: Theresa.eagleson@illinois.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

The waiver eligibility criteria covers persons from birth through 59 years of age; and persons who enter the waiver prior to their 60th birthday, and choose to remain in the waiver. Subsequently, there is no need for a transition plan, unless the individual decides to transfer to another waiver program. In that case, the counselor would inform the individual of their choices and assist him or her in moving to a different program.

Effective February 1, 2013, the State will deliver care coordination and waiver services through a mandatory managed care

delivery system for those waiver participants ages 19 and older who are enrolled in the Integrated Care Program (ICP). The program is 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 Medicaid Agency (MA) contracted with two Managed Care Plans (Plans). Participants have the choice of Plans.

Between February 2013 and January 2014 the program will be expanded to the following counties: Winnebago, Boone, McHenry, Rock Island, Mercer, Knox, Stark, Peoria, Tazewell, Logan, Menard, Sangamon, Christian, Macon, DeWitt, Mclean, Piatt, Ford, Champaign, Vermillion, Madison, St. Clair, Clinton and the City of Chicago.

The state has selected the following MCOs pursuant to an RFP to participate in the expanded program: Aetna Better Health, IlliniCare Health Plan, Community Care Alliance of Illinois (CCAI), HealthSpring of Illinois, Meridian Health Plan, Health Alliance, and Molina Healthcare of Illinois.

Outside Cook and the Collar Counties, each county will have no more than two MCOs with the exception of seven counties in Northern and Central Illinois that will have three MCOs.

The Medicaid Agency (MA) implemented the ICP for physical health and other state plan services on May 1, 2011 as Service Package I, in order to establish participant relations and provider networks. Select long term care services, including several 1915 c) waivers are being added under Service Package II of the ICP. Once Service Package II is effective, all ICP enrollees in these areas will have their waiver services administered through their Plan, to more effectively coordinate and meet the total needs of the participant.

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

Eight Managed Care Organizations (Plans) were chosen by the MA for MMAI. Participants will have the choice of six Plans in the greater Chicago region and two Plans in the Central Illinois region. The MMAI demonstration project will provide coordinated care to Medicare-Medicaid enrollees in the Chicagoland area and throughout central Illinois, including Champaign, Christian, Dewitt, Ford, Logan, Macon, McLean, Menard, Piatt, Sangamon and Vermillion counties.

In order to provide a more seamless transition from the existing care coordination processes and service plans, for participants who are currently in the waiver, the Plans will maintain the current service plans for at least 180-days unless changed with the consent and input of the participants, and only after completion of a comprehensive needs assessment. Service plans will be transmitted from the Operating Agency (OA) to the Plans prior to the effective date of this amendment. Eligibility reassessments that come due during this 180-day transition will be conducted by the OA as described in the existing waiver.

Participants will remain in their current waiver program. Responsibility for payment for waiver services will simply shift from the State to the MCO. This will occur for all MCO enrollees on the same date.

For existing HCBS eligible Enrollees, the Plans will inherit a service plan and that plan will remain in place for at least a 180-day transition period unless changed with the consent and input of the Enrollee and only after completion of a comprehensive needs assessment. Existing service plans will be transmitted to MCOs prior to the effective date of enrollment. These existing HCBS eligible enrollees will remain eligible for these services until the time of the Enrollee's redetermination. Plans are expected to assess that the enrollees' needs are being met.

Plans will recruit providers. The 180-day period in which Enrollees may maintain a current course of treatment with an out-of-network provider also includes HCBS waiver providers. 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. Therefore there should be little need for transition to a different provider. After the initial contracting period, Plans will be allowed to impose a known quality standard and to terminate contracts with underperforming providers. Finally, during readiness review, the State will only authorize Plans who meet the State's network adequacy determinations to move forward. In the first year of MMAI and MLTSS options, Plans are required to contract with any willing and qualified providers currently approved to provide waiver servcies.

If a transition would be necessary, the beneficiary will be consulted in the transition, including the selection of the network

provider. If the participant does not agree to the transition, the current provider, including PCPs, may enter into a Single Case Agreement with the Plan. If the provider does not choose to enter into a Single Case Agreement with the Plan, the Enrollee will be required to transition to a network provider that is capable of meeting the Enrollee's needs.

Through the state's transition to managed long term services and supports, the state will communicate to CMS its implementation progress, timeliness with transition milestones and demonstration of the managed care plans' compliance of federal waiver assurances. The state will submit this information to CMS through quarterly monitoring reports until July 1, 2015.

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.

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:
   There is an interagency agreement in place between HFS and DRS that describes the roles and responsibilities of each agency with respect to the waiver. Annually the interagency agreement is reviewed and updated if necessary. All waiver policy and rule changes must be approved by HFS' Medical Policy Review Committee before implementing. HFS monitors waiver compliance and health safety and welfare issues through comprehensive record review and onsite monitoring. HFS assures fiscal accountability through routine fiscal monitoring as well.

   The interagency agreement outlines the HCBS waiver responsibilities of both agencies. As the Operating Agency, DRS is responsible for participant eligibility, service plan development, budgeting, enrolling waiver providers, assuring service plans are implemented and that services and providers meet standards established in the approved waiver and governing rules. The Medicaid Agency enrolls providers in Medicaid, provides oversight consultation and monitoring of waiver operations, processes federal claims and maintains an appeal process.

   HFS and 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 reviewing components of participant eligibility, service plans, provider qualifications, health and safety, case management and how the system operates and communicates customer needs and issues.

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

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

Level of Care—enrollee records are examined to determine completeness and accuracy of the MMSE/DON completed by the Operating Agency (OA).

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

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

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

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

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

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

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

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

MCOs are required to submit quarterly reports, using the format required by the MA, on specific performance

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

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

Appendix A: Waiver Administration and Operation

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

   (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
   Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
   Effective February 1, 2013, the State will deliver 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 is 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 is implementing the managed care delivery system under the State plan authority [Section 1932(a)]. Future MCOs will be used in a similar fashion over time. They are being designed in the same fashion but will also include dual eligibles.

   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.

   The program is expanding 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. Pursuant to an RFP, five additional Plans were selected to participate in the expanded program.

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

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

   For those waiver participants enrolled in an MCO, the Plans will be 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 Integrated Care Program MCOs that provide waiver services, the MA has specified for each waiver performance measure the following: responsibility for data collection; frequency of data collection/generation; sampling approach; responsible party for data aggregation and analysis; frequency of data aggregation and analysis; data source; and remediation.

For each performance measure, the data source varies according to the performance measure; for many of the measures, the sources are MCO reports and External Quality Review Organization (EQRO) medical record reviews. The data source for several measures includes customer satisfaction and quality of life surveys. MCOs are collecting this data either by evaluating 100 percent of records or through a representative sample of records, based on the specific performance measure.

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

The MA contracts with Health Services Advisory Group (HSAG) to serve as EQRO. As part of the MA's quality oversight and monitoring of the waiver providers, the EQRO will perform quarterly onsite audits of the enrollee care plans through Record Reviews. Per the MA's contract with HSAG, upon completion of record reviews, HSAG will provide an Enrollee specific summary of findings by measure and a plan and Waiver specific summary report of

findings and recommendations as appropriate. The report will include: Summary of non-compliance related to specific performance measures; Overall summary of record review findings; and Recommendations for remediation of non-compliance.

HFS and EQRO will work collaboratively to follow up with the MCOs to ensure remediation occurs within the required time frames.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The State's Quality Improvement System (QIS) have been modified to assure that the Plans are complying with the federal assurances and performance measures that fall under the functions delegated to them by the MA. The 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 will pull the sample annually and 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 will report remediation activities to the MA, at least quarterly.

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

The MA will meet quarterly with the MCOs to assess compliance with the waiver assurances and to identify and analyze trends based on scope and severity. Remediation activities will be reviewed and systems improvements will be implemented.

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

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Participant waiver enrollment	☐	☑	☐

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

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

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

Where possible, include numerator/denominator.

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

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

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:
Reports from OA

Responsible Party for 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:
2A: # and % findings of non-compliance in the areas of pre-admission screening and waiver enrollment with evidence of remediation by OA within 60 days. N: # findings of non-comp. in the areas of pre-admission screening and waiver enrollment with evidence of remediation by the OA within 60 days. D: Total # of findings of non-compliance in the areas of pre-admission screening and waiver enrollment.

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

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

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:
Reports from OA

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

Data Aggregation and Analysis:

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

Performance Measure:
4A: # and % of overdue Individual Support Plans 12 month renewals that were remediated within 30 days by the OA and MCO. N: # of overdue Individual Support Plan 12 months renewals which were remediated within 30 days by the OA and MCO. D: Total # of OA and MCO overdue Individual Support Plan 12 months renewals.

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

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

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

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

Responsible Party for 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):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:
Reports from OA

Responsible Party for 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: MCO	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
6A: # 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:	☑ **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:
7A: # and % of rate methodology changes submitted by the OA that are approved by the MA and submitted for Public Notice prior to implementation. N: # of rate methodology changes submitted by the OA that are approved by the MA and submitted for Public Notice prior to implementation. D: Total # of rate methodology changes implemented.

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

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

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

Performance Measure:
9A: # and % of service plans that were implemented prior to authorization by the OA and MCO with remediation within 60 days. N: # of service plans that were implemented prior to authorization by the OA and MCO with remediation within 60 days. D: Total # of services plans reviewed by the OA and MCO that were implemented prior to

authorization.

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

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

Data Source (Select one):
Reports to State Medicaid Agency on delegated
If 'Other' is selected, specify:
Reports from OA

Responsible Party for 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:
10A: # 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:
Reports from OA

Responsible Party for 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:
11A: # and % of required MCO reports submitted according to contract requirements. N: # of MCO required reports submitted according to contract requirements. D: Total # of MCO required reports.

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
14A: # and % of waiver service providers utilized by the MCO that are an enrolled Medicaid provider. N: # of enrolled certified waiver service providers utilized by the MCO that continue to meet applicable certification requirements. D: Total # of enrolled certified waiver service providers.

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

MCO Reports

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

Data Aggregation and Analysis:

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

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

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

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

4A: The OA/MCO conducts timely completion of the overdue Support Plans and renewals. The OA/MCO may also provide training for case managers. 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.

5A: The OA obtains provider qualifications documentation. The MCO will work with providers and the OA to obtain documentation. If not qualified, the provider is dis-enrolled and the OA/MCO provides participant with other available providers. The OA/MCO trains case managers, if needed. 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.

6A: The OA will obtain Medicaid provider agreements. The MCO will work with providers and the OA to obtain Medicaid provider agreements. If not qualified, the provider is dis-enrolled and the OA/MCO provides participant with other available providers. The OA/MCO trains case managers, if needed. 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.

7A: 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.

8A: 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.

9A: 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.

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

11A: MA will require completion of overdue reports. 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.

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

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

14A: Upon discovery of non-compliance, the MCO is notified to change the provider. The MCO will work with providers and the OA to become an enrolled Medicaid provider. Training for MCO case managers. Remediation must be completed within 60 days.

ii. Remediation Data Aggregation

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

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

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
[x] Aged or Disabled, or Both - General					
	[ ]	Aged			[ ]
	[x]	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) assessment, with a minimum score of 15 on functional impairment and a total of 29 points
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 as measured by the DON.

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

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

Specify:

The particpant 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 Department on Aging's waiver for persons who are elderly (age 60 or older.)

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Specify the percentage: [ ]

- ○ **Other**

Specify:

[ ]

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

(●) **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

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

The University of Illinois-Chicago conducted a study to review the Determination of Need assessment tool (DON) to determine validity and possible need for revision. The study was a cooperative venture, which included the Department of Rehabilitation Services (now DHS-Division of Rehabilitation Services-(DRS)), Department of Public Aid (now Department of Healthcare and Family Services-(HFS)), and the Department on Aging (DoA). The tool was developed for two purposes: 1) as a prescreening tool for HCBS waivers for DHS-DRS, DoA, and nursing facilities and 2) as a tool to assess level of services in HCBS waivers and to identify service cost maximums, based on the case-mix strata.

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

Analyses also identified ranges of DON scores, and associated Service Cost Maximum 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 installation of the AMD and the EHRS are not included in the Service Cost Maximum; however, the monthly rates are included.

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 for State Fiscal Year 2012

DON Range	Monthly Service Cost Maximum
29-32	$2,083
33-40	$2,300
41-49	$2,567
50-59	$3,078
60-69	$3,616
70-79	$3,910
80-100	$4,203

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 at least a minimal total score of 29 on the DON, with at least 15 impairment points. The range of scores and corresponding SCM is indicated under B-2 a. This amount directly corresponds to the amount the State would expect to pay for the nursing care component of institutionalization if the individual chose institutionalization.

The ranges were determined via research that was conducted by the University of Illinois Chicago, Gerontology Department. The purpose of the study was to verify that the DON scoring corresponded with impairment and need. The SCMs were developed by determining institutional costs incurred by individuals with similar DON scores. 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.

Presently, Section 682.100 (g) requires a physician's certification at least every two years that "indicates the individual is in need of long-term care and this care can safely and adequately be provided in the individual's home according to the physician and the HSP Service Plan". By 2/28/14, the OA will file an emergency rule with Illinois' Joint Committee on Administrative Rules (JCAR) to eliminate this requirement. An emergency rule is in effect for 150 days, so a proposed rule to make the change permanent will be filed at the same time; it will go through JCAR's standard process for this type of rulemaking. More info about Illinois' Rulemaking Process can be found at http://www.ilga.gov/commission/jcar/ILRulemakingProcess.pdf.

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	30300
Year 2	31593
Year 3	33489
Year 4	35498
Year 5	37728

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

  Select one:

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

  Specify percentage: [ ]

- ☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☑ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☑ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

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

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

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

◉ **Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

○ **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

☑ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☑ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

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

Specify percentage amount: [ ]

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-c (209b State) and Item B-5-d)

◉ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-c (209b State). Do not complete Item B-5-d)

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

  (*select one*):

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

    Specify:

    [ ]

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

    (*select one*):

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

      Specify percentage: [ ]

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

      Specify dollar amount: [ ]

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

    Specify percentage: [ ]

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

    Specify:

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

- ( ) **The following dollar amount**

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

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

Specify:

○ **Other**

Specify:

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

◉ **Not Applicable (see instructions)**

○ **The following standard under 42 CFR §435.121**

Specify:

○ **Optional State supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

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

◉ **Not Applicable (see instructions)**

○ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

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

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

Specify:

Other
Specify:

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

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

Select one:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-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 (6 of 7)

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

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

Answers provided in Appendix B-5-a indicate 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 (7 of 7)

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

- ○ **Directly by the Medicaid agency**
- ◉ **By the operating agency specified in Appendix A**
- ○ **By 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.

In order to be eligible for waiver services, the customer must be evaluated with the Illinois Determination of Need (DON) assessment and receive at least 15 points on functional impairment and a total of 29 points. This assessment includes a mini-mental state examination (MMSE) and functional status section. The functional status section assesses both activities of daily living (ADL) and instrumental activities of daily living (IADL). The functional areas are: eating, bathing, grooming, dressing, transferring, incontinence, managing money, telephoning, preparing meals, laundry, housework, outside of home, routine health, special health, and being alone. Each area is scored 0-3 for level of need, and 0-3 depending on the level of natural supports available to meet the need. The score of 0 is no need increasing up to total dependence with a score of 3. Mental status is evaluated using the standardized Mini-Mental State Exam. HSP Counselors receive training and guidelines for scoring each area consistently. The DON is the same criteria used to assess for nursing facility eligibility. The final score is calculated by adding the results of the MMSE, the level of impairment and the unmet need. State rules regarding prescreening are found in 89 Il Admin Code, Part 681. State rules pertaining to the DON are found in 89 Il Admin code, part 679.

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

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

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

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

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 as described in the existing waiver.

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

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

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

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

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

The operating agency utilizes a Virtual Case Management 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:

The HSP Counselors maintain evaluations and reevaluations. The Virtual Case Management system also maintains the evaluations and reevaluations electronically, for all participants including those enrolled in an MCO.

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports from OA: Reassessment of eligibility report (WCM)

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

Data Aggregation and Analysis:

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

	Specify:

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

Performance Measures

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

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

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

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

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

	Specify:	

Data Aggregation and Analysis:

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

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

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

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

		Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Semi-Annually	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Virtual Case Management (VCM) System has built-in edits to reject any assessments that do not meet the 29-point criteria for the Determination of Need. It also has built-in reports to determine when assessments are due or overdue. The built-in edits are ongoing. The reports may be run as often as needed.

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

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

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

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

17B: If it is discovered that the documentation does not support the LOC, the OA will require a justification from case managers for the eligibility determination. If the justification, is inadequate, the waiver eligibility will be discontinued and the OA will assist the individual with accessing other supports and services. Federal claims will be adjusted and the OA will provide technical assistance or training to case managers. Remediation must be completed within 60 days.

18B: If it is determined that the case manager is not a qualified evaluator, the LOC will be redone by a qualified case manager. If the participant is eligible, no additional correction will be required. If the participant is ineligible, the individual will receive assistance with accessing other supports and services. The OA will also provide training or technical assistance to assure that all case managers meet qualification requirements. Remediation must be completed within 60 days.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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.

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 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	**Personal Assistant**
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:**

Service Definition *(Scope):*
Services are furnished on a regularly scheduled basis, for one or more days per week, in a congregate setting encompassing both incidental health care and social services needed to ensure the optimal functioning of the consumer. Meals provided as part of these services shall not constitute a full nutrition regimen (three meals a day). Transportation is included in the Adult Day Care service and is paid by DRS as a separate rate component.
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 Care

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Care

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

89 Il 686.100

Verification of Provider Qualifications

Entity Responsible for Verification:

DRS

Frequency of Verification:

Every 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:**

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):
Personal Assistant

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Personal Assistants provide assistance with eating, bathing, personal hygiene, and other activities of daily living in the home and at work (if applicable). These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include 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. Personal care providers meet state standards for this service. Personal care will only be provided when it has been determined by the case manager that the consumer has the ability to supervise the personal care provider. The personal assistant is the employee of the consumer. The state acts as the fiscal agent for the consumer.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
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. Personal Assistant Services 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 a care provider.

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal Assistant

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Assistant

Provider Category:
Individual
Provider Type:
Personal Assistant
Provider Qualifications
License *(specify):*

N/A
Certificate *(specify)*:
N/A
Other Standard *(specify)*:
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:**

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 provided to a consumer to provide his or her activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. It may be provided in the following places: individual's home; or in an adult day care setting.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The amount, duration, and scope of services is based on the determination of need assessment conducted by the case manager and the service cost maximum determined by the DON score.

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

- [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	LPN
Individual	Personal Assistant
Agency	Adult Day Care
Agency	Home Health Agency
Agency	Homemaker
Individual	Home Health Aide
Individual	RN

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
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:
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:
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:
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: 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:**

Service Definition *(Scope):*
Services that are part of the treatment plan outlined by the attending physician. 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)*:

- [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
Agency	Home Health Agency

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Home Health Aide
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
210 ILCS 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: Provider Specifications for Service

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
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)*:

- [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	Occupational Therapist

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: 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: 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:**

Service Definition *(Scope):*
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)*:

- [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	Physical Therapist

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: 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: 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:**

Service Definition *(Scope):*
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
Agency	Home Health Agency
Individual	Speech Therapist

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Speech Therapist
Provider Qualifications
License *(specify):*
225 ILCS 110
Certificate *(specify):*
N/A
Other Standard *(specify):*
N/A
Verification of Provider Qualifications
Entity Responsible for Verification:
DRS
Frequency of Verification:
At time of enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

HCBS Taxonomy:

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

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.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The cost of environmental modification, when amortized over a 12 month period and added to all other monthly service costs, may not exceed the service cost maximum (89 Ill. Adm. code 679) established for the customer's case.

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

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

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:**

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.

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	LPN
Individual	Registered Nurse
Agency	Home Health Agency

Appendix C: Participant Services

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

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

Provider Category:
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: 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: 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:**

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.

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
Individual	LPN
Agency	Home Health Agency
Individual	Registered Nurse

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 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:
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:
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:**

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergency Home Response

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:**

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

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.

Personal assistants (PA) hired independently by the customer are excluded from the act due to grass roots 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.

DRS gives 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.

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. Personal assistants 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 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.

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:
19C: # 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**	☑ **Annually**

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

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

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

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

Data Aggregation and Analysis:

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

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

	Ongoing	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:
22C: # and % of enrolled certified waiver service providers who continue to meet applicable certification requirements (same provider types as 22C). 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:
23C: # and % of MCOs that initially meet contract requirements prior to furnishing waiver services. N: # of MCOs who initially meet contract qualifications prior to furnishing services. D: Total # of MCOs furnishing waiver services.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
24C: # and % of contracted MCOs that continue to meet contract qualification

requirements. N: # of contracted MCOs who continue to maintain contract qualification requirements. D: Total # of contracted MCOs.

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

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

Data Aggregation and Analysis:

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

☐ **Other**
Specify:

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:
25C: # and % of newly enrolled non-licensed/non-certified waiver service providers, by provider type, who meet initial waiver provider qualifications (Includes: ADC, homemaker, EHR). N: # of newly enrolled non-lic./non-cert. waiver providers reviewed, by provider type, who meet initial waiver provider qual. D: Total # of newly enrolled non-lic./non-cert. waiver 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:
26C: # and % of non-licensed/non-certified waiver service providers, by provider type, who continue to meet waiver provider qualifications (same provider types as 25C). N: # of enrolled non-lic./non-cert. waiver service providers reviewed, by provider type, who continue to meet provider qualifications. D: Total # of enrolled non-lic./non-cert. waiver service 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:
27C: # 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 initial 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	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

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

Data Aggregation and Analysis:

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

Performance Measure:
28C: # and % of non-licensed/non-certified waiver service providers, by provider

type, who continue to meet waiver provider qualifications (same provider types as 27C). N: # of enrolled non-lic./non-cert. waiver providers reviewed, by provider type, who continue to meet waiver provider qualifications. D: Total # of enrolled non-lic./non-cert. waiver 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 = +/-5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

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

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

Performance Measure:
29C: # and % of case managers who meet waiver provider training requirements. N: # of OA and MCO case managers reviewed who meet waiver provider training requirements. D: Total # of OA and MCO case managers reviewed.

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

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

	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports 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 Aggregation and Analysis:

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

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

Performance Measure:
30C: # and % of OA homemaker agencies who meet waiver provider training requirements. N: # of OA homemaker agencies reviewed who meet waiver provider training requirements. D: Total # of OA 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 = +/-5%
☐ **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 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.
19C:Provider will be notified by the OA of lacking documentation. Receipt of respective provider licensure

documentation or disenroll. Remediation within 30 days.

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

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

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

23C:The MCO will be notified by the MA of lacking documentation. Receipt of documentation to meet contract requirements or unable to contract. Remediation within 60 days.

24C:Remove as a MCO in MMIS and require the documentation be submitted to meet contract requirements. Change of MCO for enrolled wavier participants; Remediation within 60 days.

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

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

27C:Provider will be notified by the OA of lacking documentation. Receipt of respective provider licensure documentation or disenroll. Remediation within 30 days.

28C: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.

29C:Completion of case manager training; Moratorium of new PD cases to non-certified OA/MCO case managers. Remediation within 60 days.

30C:Complete the training requirements. OA must submit a plan for how to assure training requirements are continually met. Remediation within 60 days.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design

methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

Exceptional Care Rate
The exceptional care rate (ECR) for individuals who cannot be served under an HSP waiver's SCM is established by the Department of Healthcare and Family Services (HFS). This rate is comparable to the assessed cost for nursing facility care of persons with similar needs and shall not be exceeded.

The installation is not included in the monthly Service Cost maximum, howevr, the monthly rates are included.

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.

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:

1) 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.

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

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

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

- [ ] **Social Worker**

Specify qualifications:

- [ ] **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

The State has established the following safeguards to ensure that service plan development is conducted in the

best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

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

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

OA Process:
The service plan is developed based upon the results of the Determination of Need (DON) assessment. The DON identifies functional limitations and unmet support needs that must be addressed on the service plan to maintain and maximize customer independence.

The OA Counselor uses the service planning process to discuss services available to the customer under the waiver. Customers (and their designees) actively participate in plan development and are informed as to the various service options that are available to them. Customers are provided choice regarding the type and scope of supports, frequency of services, units of service, and the provider of service. Along with the standard service plan, the Counselor also completes a Person Centered Goal addendum to the service plan. This form addresses needs outside the waiver that the customer may have including housing, recreation, employment, and mental health.

The customer, their designee, or guardian, have the opportunity to actively participate in all aspects of assessment and service planning. Customers agree to, and must sign, service plans before services are implemented. 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). The customer takes the lead in selecting qualified providers. Customers are informed of the choice of self-directing services and are provided information on serving as an employer and managing a personal assistant.

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

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

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

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

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

OA Process:
Following determination of program eligibility, the OA Counselor and the customer develop a service plan. The service plan directly relates to the customer's need for care, as identified on the DON.

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

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

OA Process:
Service needs are identified 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 customer's individual care needs are met by family members or other supports. This tool is then used to update the service plan. A comprehensive assessment is also completed to identify service needs outside of the waiver, such as housing, employment, recreation and mental health. The needs assessment is an addendum to the service plan.

MCO Process:
The Plans have comprehensive assessment tools that contain components that are used to elicit comprehensive information from the participants to support service plan development. These components in the assessments include but are not limited to cognitive/emotional ADLS, IADLS, behavioral health, medication, living supports, environmental conditions, and health care information. The Plans also review the Determination of Need, conducted by the OA. The assessment secures information including the member's strengths, needs, levels of functioning and risk factors. Through the assessment and care planning process the participant's goals and the strengths and barriers to achieving these goals are identified. The comprehensive assessment tools used by the Plans are reviewed by the Department and its EQRO prior to implementation.

c) Informing customer of services available under the waiver:

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

MCO Process:
The participant is informed by the Plan of the covered waiver services:

- At the initial face-to-face visit by the case manager; in conjunction with the review of the member handbook/inserts

- Annually when the Plan's case manager reviews the member handbook/inserts with the participant

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

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

MCO Process:
Comprehensive assessments are developed by the MCOs. The MCO contract specifies expectations for waiver clients, including content of and purposes for Enrollee Care Plans and HCBS Waiver service plans (for enrollees receiving HCBS Waiver services).

After the comprehensive assessment has been completed by the MCO, and the array of services have been presented to and discussed with the participant, the Plan's case manager, the participant and/or their representative(s) formulate a care plan that addresses their goals, the strengths and barriers/risks in consideration of these goals, and the mutually agreed upon activities for their achievement. As this is participant-centric, personal preferences are integral to the development of the service plan. The service plan includes the type, amount, frequency, and duration of waiver services, and may include services and supports not covered under the waiver.

As part of its work on behalf of 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:
Services are coordinated to assist persons in becoming as independent as possible. The HSP Counselor and customer work together to design a set of services that are comprehensive and meet each customer's needs. The service plan is approved by customer and counselor, and signed by both.

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

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

OA Process:
During the plan development process, the HSP Counselor discusses services and choices of providers. In addition the consumer is given instructions on how to request a change in the plan if the customer's situation changes. HSP Counselors explain to customers at all assessments that the customer needs to notify the counselor at any time that there is a change in their living (or medical) situation that may affect their services.

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

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

OA Process:
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 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.

Lastly, the customer is given appeal rights, if not satisfied with the amount or type of services authorized. Customers have the right to appeal any decision made by the HSP Counselor concerning their case. Customers are also informed of their responsiblities including: 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 assist DRS on gathering the information necessary to determine eligibility, the requirement to report all changes in circumstances which may effect eligibility or continued eligibility for services to DHS, as soon as known.

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

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

The participant is in the center of the care/service planning process. The Plan case management staff will complete a comprehensive assessment to identify the participant's strengths, needs, formal and informal supports based on information provided by the participant or representative. The participants have an active role in choosing the types of services and service providers to meet those needs. The case manager will obtain the waiver participant's signature of agreement on the service plan and will offer the waiver participant a choice of providers to fulfill the services

The Plan's case manager is responsible for providing clear direction to the participant regarding appeal rights whenever a reduction, termination, or suspension in service(s) occurs. The appeal rights are summarized in the service plan that the participant signs at the initial assessment, and each reassessment thereafter. If the member appeals, the services will remain intact until the appeal process is exhausted, including the State Fair Hearing. The member handbook/inserts that are provided to and reviewed with the participant also provide information on appeal rights and processes.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

OA Process:
The OA Counselor must address the consequences of negative choices, during the planning process, which may involve risks and document the issues of concern and the decisions made. This discussion is maintained between the OA Counselor and the customer during initial assessment, and subsequent reassessments. The customer is assessed with respect to risks and potential risks, 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. The customer's need for service is then ascertained, and it is determined whether or not a service plan may be developed which will effectively eliminate potential risks.

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

Once eligibility has been determined, a plan of care is developed with the customer. The customer must agree that the services will safely and adequately meet their needs, and signify this by signing the service plan. Customers are encouraged to completely participate in plan development. No plan may be implemented unless approved by the customer, their designee, or guardian. 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).

At initial assessment and during subsequent reassessments, the customer is informed of his or her rights and responsibilities, and must be forthcoming about the level of unpaid care that is or is not available. Once the plan has been implemented, the HSP Counselor will contact the customer at least annually to determine consistency of service provision, and also to determine whether or not level of care continues to meet customer's needs. The customer must notify the HSP Counselor of any changes that may affect eligibility and provision of services.

Every service plan must have a backup plan, which is documented in the service plan on the signature page. If the provider is an agency then the agency is responsible to assure that there is a back-up plan in place. 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 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 customer has lost a personal assistant and is going through the interviewing and hiring process to obtain another personal assistant, DRS 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 participants enrolled in an MCO, the Plan care coordinator is the lead for waiver service planning. The assessment for potential risk is included in the service plan development process. The care coordinator will incorporate into the service plan, strategies to mitigate risks identified, including the backup plan and arrangements for back-up.

The Plan’s case manager completes a comprehensive assessment and care planning process for every participant. This process includes identification of the participant’s cognitive/emotional functioning, behavioral health, medication, living supports, environmental conditions, ADLS, IADLS and health information. This process identifies risks that may increase and serve as barriers to the members’ ability to live as safely and independently as possible. Risks may include, but are not limited to, substance abuse, non-adherence to treatment, and environmental safety concerns. All risks are identified and discussed in the service planning process. Through service planning interventions, identified risk(s) are mitigated and barriers are addressed with interventions which are mutually agreed upon by the participant and the Plan.

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

arrangement. The list may consist of family, friends, community supports, or provider agencies.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

OA Process:
Approximately 85% of the providers in this program are personal assistants that are hired and trained by the consumer. HSP Counselors assist consumers in identifying potential personal assistant providers as well as traditional providers. When a personal assistant is chosen, the counselor gives the 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. If a traditional provider is chosen HSP Counselors share a list of approved providers with the consumer, who then chooses from the list.

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

It is the Plan's case manager's role to provide information about the available services and service providers to each participant, and to answer any questions that arise. The Plan will assist the participant through the complex provider network supplying provider information relevant to the services selected by the member on their service plan and available in the member's service area. Participants always have first choice on the providers they select to meet their needs. Plan case management staff will support the participant in selecting a provider to meet their needs if the participant does not have a preferred provider identified. The Plan maintains a current list of qualified and contracted service providers which is made available to participants upon request. The participant is also educated that the Plan's provider list is available on the Plan's website.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

A representative sample is selected by the MA on an annual basis. The MA's sampling methodology is based on a statistically valid 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 methodology is adjusted as additional MCOs are enrolled.

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 OA and the EQRO determine a review schedule, based on the sample and performs onsite record reviews to assess compliance with the service plan performance measures. For the MCOs, the EQRO sends a report of findings to the MA and the MCOs. The MCOs are required to remediate findings within required timelines, and report remediation activities to the MA, at least quarterly. The MCOs report on both individual and systemic remediation.

For the OA, plans of care are reviewed by both the MA and the OA's Quality Assurance unit. The MA reports findings to the OA along with recommendations for improvement. During quarterly meetings, the OA reports on the combined review findings and corrective actions. The OA reports on both individual and systemic remediation.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

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

Specify the other schedule:

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

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

Specify:

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

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The 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 customers, annually, at a minimum. Additionally, when problems are reported, case managers respond by meeting on a more frequent or as-needed basis.

Case managers monitor service plans throughout the service period as follows:

1.For customers using homemaker and home health agencies, case management staff review 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.

2.For customers who have personal assistants, case management staff review billings twice a month to ensure services are provided in accordance with service plan. If there are issues with the provision of services, case management follow-up with the customer to rectify the situation.

3.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 Virtual Case Management System and the VCM 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.

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

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

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

The case manager also reviews the backup plan to ensure it is still in effect and if the backup plan was utilized, it is discussed with the participant to ensure its effectiveness. The service plan, service providers, backup plan or referrals to non-waiver services may be made or modified to ensure the member's needs are adequately met based on these discussions.

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

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

The HSP Quality Assurance Unit then 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 will develop a statewide summary report of monitoring activities. The reports will be shared during Quality Improvement meetings with HFS to discuss trends, patterns, remediation and quality improvement methods on a system-wide level.

HFS oversight monitoring:

HFS program monitoring activities 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 plan includes a statement that the participant 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 back up 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.

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

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:
31D: # 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 = +/-5%
☑ **Other** Specify: EQRO/MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
32D: # 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:
MCO Reports; EQRO Reviews

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

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

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

		+/-5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
33D: # and % of OA and MCO participants' service plans that address risks identified in the assessment. N: # of OA and MCO service plans reviewed that address risks indentified in the assessment. D: Total # of OA and MCO service plans reviewed.

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

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

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

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

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

☐ **Other**
Specify:

Data Aggregation and Analysis:

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

Performance Measure:
34D: # and % of OA and MCO satisfaction survey respondents in the sample who reported they receive services they need when they need them. N: # of OA and MCO satisfaction survey respondents who reported they receive services when needed. D: # of OA and MCO satisfaction survey respondents in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; POSM Survey question A.2

Responsible Party for 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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports; POSM Survey question A.2

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% of the population selected randomly by region
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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:
35D: # and % of OA and MCO participants' service plans that were signed and dated by the waiver participant and the case manager. N: # of OA and MCO service plans that were signed by the waiver participant and the case manager. D: Total # of OA and MCO service plans reviewed.

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

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

		Interval = +/-5%
☑ **Other** Specify: EQRO/MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

Performance Measure:
36D: # 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:
MCO Reports; EQRO Reviews

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

	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

Specify: MCO	
	☐ **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:
37D: # and % of OA and MCO waiver participants who have their Service Plan updated every 12 months. N: # of OA and MCO waiver participants reviewed who have their Service Plan updated every 12 months. D: Total # of OA and MCO waiver participants with service plans due during the period reviewed.

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
38D: # and % of OA and MCO waiver participants that received updates to service plans when participants needs changed. N: # of OA and MCO waiver participants reviewed that received updates to service plans when participants' needs changed. D: Total # of OA and MCO waiver participants identified whose needs changed.

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

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

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:
39D: # and % of OA and MCO participants who received services in the type, scope, amount, duration, and frequency as specified in the service plan. N: # of OA and MCO participants reviewed who received services as specified in the service plan. D: Total # of OA and MCO participants reviewed.

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

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

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

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

Data Aggregation and Analysis:

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

	☐ **Other** Specify:

Performance Measure:
40D: # and % of OA and MCO satisfaction survey respondents in the sample who reported the receipt of all services listed in the plan of care. N: # of OA and MCO satisfaction survey respondents who reported the receipt of all services listed in the plan of care. D: # of OA and MCO satisfaction survey respondents in the sample.

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

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

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

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

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% of the population selected randomly by region
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between 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:
41D: # and % of OA and MCO participants records with the most recent plan of care indicating the participant had choice between waiver services and institutional care; and between/among services and providers. N:# of OA and MCO participant records reviewed with a signed POC that indicates part. had choice between waiver services and providers. D:Total # of OA and 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 = +/-5%
☑ **Other** Specify: EQRO and MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

OA Reports: HSP QA Audit Reports

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

Data Aggregation and Analysis:

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

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.

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

32D:If 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.

33D: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.

34D: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.

35D: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.

36D: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.

37D: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.

38D: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.

39D:If a participant does not receive services as specified in the service plan, the OA//MCO will determine if a correction or adjustment of service plan, services authorized, or services vouchered is needed. If not, services

will be implemented as authorized. The OA//MCO may also provide training to case managers. If the issue appears to be fraudulent, it will be reported by the OA/MA to fraud control. Remediation must be completed within 60 days.

40D: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.

41D: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. Customers may either hire their own service providers or use an agency provider. Customers are encouraged to use their own service providers, whenever possible.

Most customers choose to hire personal assistants (PA) for their care. PAs are individual service providers that are hired by, and are directly supervised by customers. In addition, if particular PAs are not performing to customer satisfaction, the customer may take disciplinary action against the PA, including discharge. Customers work with PAs to arrange work schedules to address services identified on the service plan, and to meet customers' scheduling needs as well. Customers may either directly train PAs in effectively meeting their particular services needs, or may coordinate PA training through another resource.

As the employer, 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 plan of care. In the event that it is determined that a customer is unable to appropriately supervise a PA, the service may be changed to homemaker, or another service. When this occurs, the 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 customers do not have the capacity to appropriately supervise a PA, or when a PA cannot be located for the customer. Homemakers are supervised by their respective homemaker agency. Again, the customer may select an agency of their choice. Homemaker services are provided in accordance with the plan of care, and in accordance with provisions specified in a rate agreement with DHS. Other individual (non-agency) providers may include home health aide, licensed practical nurses, registered nurses, or therapists. Customers may still opt to select their preferred provider for nursing care or therapy, however due to the clinical nature of nursing and therapies, 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 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, 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, 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 customerÃƒÂ,Ã,Â'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 customers about participant directed services and choice of worker. Customers are given a "Customer Packet", which includes: a Personal Assistant Packet; guidelines for self-directed care; Rights and Responsibilities brochure, which includes the right to appeal, informal resolution, and information about the Client Assistant Program (CAP); Employment Agreement; Optional Criminal Background Check form; and a Medicaid provider agreement.

The personal assistant packet includes the following: the customer and PA employment agreement form, which describes the relationship between the PA and customer and the employment arena and the PA standards form, which allows the PA to list their qualifications and work 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 customer also receives the HSP Application and Redetermination of Eligibility Agreement that contains information such as: customer rights and responsiblities, abuse and neglect reporting, choice, and services. HSP Counselors review this form with customers when there is a change in service or minimally, at each redetermination. 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 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)*:

- [x] **Waiver services may be directed by a legal representative of the participant.**
- [x] **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A customer 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 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 customer's parent, family member, guardian, or duly authorized representative may act on behalf of the customer and is included within the definition of "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 customer.

Non-legal representatives will only participate in the assessment process when so designated by the customer, and also will only participate in the decision-making process when approved by the customer.

Safeguards are in place to protect the customer when non-legal representatives are involved. These safeguards are described below:

Counselors meet with customers at least annually. Customers are provided with an information folder which includes information about their case, their appeal rights, and DHS contact information. 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, the appropriate Office of Inspector General is notified, as well as DHS administration. If HSP believes that the customer is in immediate danger, the local police are notified. If the allegations are validated by OIG, additional instructions may be provided to DHS by OIG, which may require follow up. In cases of suspected abuse by a service provider, that provider is removed from service, and a new provider is assigned to the 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	☑	☐
Personal Assistant	☑	☐
In-Home Shift Nursing	☑	☐
Home Health Aide	☑	☐
Intermittent Nursing	☑	☐
Speech Therapy	☑	☐
Occupational Therapy	☑	☐
Physical Therapy	☑	☐

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 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. All workman'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:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [ ] **Maintain a separate account for each participant's participant-directed budget**
- [ ] **Track and report participant funds, disbursements and the balance of participant funds**
- [ ] **Process and pay invoices for goods and services approved in the service plan**
- [ ] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☐ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☐ **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The FMS is 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:

Customers are informed of the type of availability of services offered through the Persons with Disabilities waiver. Additionally, customers have the right to choose their service providers, for example which physician they will see, or which HSP approved vendor will provide them with goods or services (Section 677.40 Freedom of Choice). At initial eligibility determination, customers are informed of the variety of services available through the "Customer Guidance on Rights/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 customer during assessments.

HSP Counselors are responsible for providing information and support to customers. Customer rights and responsiblities are explained to the customers, as well as the purpose and scope of the program, and information concerning the types of available services.

Customers using Individual Provider services are required to collect and certify certain information for each

Individual Provider used. If the 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 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.

Customers are informed about their right of self-direction during the initial eligibility assessment and subsequent reassessments. This is reviewed with the customer through a variety of methods:
• 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 customer satisfaction are reviewed on the "Personal Assistant Evaluation" form.

All of this information is discussed with the customer, and the customer signs the forms to indicate that the information has been reviewed. Additionally, 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	☑
Personal Assistant	☑
Adult Day Care	☐
In-Home Shift Nursing	☑
Environmental Accessibility Adaptations	☐
Home Health Aide	☑
Home Delivered Meals	☐
Intermittent Nursing	☑
Specialized Medical Equipment	☐
Speech Therapy	☑
Occupational Therapy	☑
Personal Emergency Response System	☐
Physical Therapy	☑

☑ **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 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 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 customer has the capacity to self-direct and chooses a personal assistant, the service plan is developed and the customer is provided information about becoming an employer of the personal assistant.

If the 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 customer chooses to self-direct and there are problems with the personal assistant such as fraud or abuse by customer; or situations where the customer's physical or mental health regresses, the case manager will work with the 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 are provided until case 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 customers in the management of Personal Assistants. When a customer goes from self-directing services to receiving agency-based services and wants to go back to self-direction, HSP suggests that the customer participate in the training.

When a customer is in between personal assistants, DRS immediately increases the service plan and contacts a homemaker agency to maintain continuity of care as the 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 provider-managed services. In order to assure the participant's health and safety and no interruption in services the Plan will coordinate the transition from self-direction to provider-managed services to assure no break in services.

Voluntary terminations will be recorded on the participant's service plan and will be indicated by the participant's

approval of the new service plan.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Services provided by a personal assistant will only be provided when it has been determined by the 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 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 (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	30917	

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 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 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 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 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 redeterimination of eligibility. Previously, there was a requirment for physician's approval. As explained in more detail in Appendix B-2-b, the OA is working to eliminate the physician certification requirement in Section 682.100(g));
-Fails to cooperate (e.g., refuses to complete and sign necessary forms, fails to keep appointments, fails to maintain adequate providers) or
-Cannot have a safe and adequate service plan developed for him/her as a result of the original determination of eligibility or redetermination of eligibility. Previously, there was a requirement for physician's approval. As explained in more detail in Appendix B-2-b, the OA is working to eliminate the physician certification requirement in Section 682.100(g).
When a OA counselor makes an adverse case decision, the customer will receive a service notice that explains the decision and informs the customer of his/her right to appeal. The service notice is sent to the customer at least 15 days prior to the effective date of the action. The counselor is responsible to notify the customer immediately after the decision. If the

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 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 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. 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. (CustomerÂ's Guidance on Rights/Responsibilities/Appeals Procedures; Section 510.100 Informal Resolution Conference.)

Â"Informal resolutionÂ" 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 customerÂ'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 customerÂ'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 MCOâ€™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 respective OIG 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 the respective Office of Inspector General 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 maintain and monitor 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, DHS-OIG 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 PlanÂ'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:

Â•An informal system, available internally, to attempt to resolve all grievances;
Â•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 EnrolleeÂ's health so necessitates);
Â•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;

Â•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;
Â•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;
Â•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
Â•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 Ã‚Â– 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 childÃ‚Â'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 Ã‚Â– 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:

The operating agency (DHS) Office of the Inspector General (OIG), which is a semi-independent entity that reports to both the Governor and the Secretary of DHS, investigates alleged abuse, neglect and exploitation of adults with mental, developmental, or physical disabilities in private homes and of adults with mental or developmental disabilities in DHS-funded community agencies.

The DHS Office of Inspector General Adults with Disabilities Abuse Project has statutory authority to respond to allegations related to adults with disabilities between the ages of 18 and 59 who reside in domestic situations. OIG has authority to investigate, take emergency action, work with local law enforcement authorities, obtain financial and medical records, and pursue guardianship. With the individual's consent, substantiated cases are referred to DHS for development of a service plan to meet identified needs.

OIG Hotline Number: 1-800-368-1463 (voice and TTY)

Participants 60 years of age or older:

Persons can report suspected abuse, neglect or exploitation to DoA by utilizing the Elder Abuse Hotline number at 1-866-800-1409, available 24 hours a day, seven days a week, or to the Senior Help Line number, 1-800-252-8966, during regular business hours. After-hour and weekend calls are automatically transferred to the Elder Abuse Hotline number.

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 AgencyÃ¢Â€Â™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:
ÃÂ€Â¢ Death
ÃÂ€Â¢ Suspicious death
ÃÂ€Â¢ Falls
ÃÂ€Â¢ Serious physical injury
ÃÂ€Â¢ Hospital admission
ÃÂ€Â¢ Misuse of funds
ÃÂ€Â¢ Medication error
ÃÂ€Â¢ Unauthorized use of restraint, seclusion or restrictive physical or chemical restraints
ÃÂ€Â¢ Elopement or missing person

Ã¢Â€Â¢ Fires
Ã¢Â€Â¢ Severe natural disaster
Ã¢Â€Â¢ Possession of firearms (participant or staff)
Ã¢Â€Â¢ Possession of illegal substances (participant or staff)
Ã¢Â€Â¢ Criminal victimization
Ã¢Â€Â¢ Financial exploitation
Ã¢Â€Â¢ Suicide or attempted suicide

For these types of incidents, if there is a perceived immediate threat to a memberÃ¢Â€Â™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, 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.

For participants enrolled in an MCO, the Plan shall train all of PlanÃ‚Â'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 PlanÃ‚Â'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 EnrolleesÃ‚Â' family members will be trained about the signs of Abuse and Neglect, what to do if they suspect Abuse or Neglect, and the PlanÃ‚Â'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 StateÃ‚Â'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 Ã‚Â"out-of-homeÃ‚Â" 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 perpetratorÃ‚Â'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:

Administrative rules for the Office of Inspector General state that an employee, community agency or facility shall report any allegation of abuse, neglect, or financial exploitation immediately, but no later than within four hours after the initial discovery of an incident of alleged abuse or neglect. The required reporter shall report the allegations by phone to the OIG hotline. The authorized representative of the community agency or facility shall notify the victim or guardian (if applicable) and the accused that an allegation has been received within 24 hours. If the authorized representative or designee is unable to reach the guardian by phone, a letter of notification shall be sent within 24 hours. The Office of Inspector General shall also contact the complainant immediately but no later than within three working days regarding the allegation.

When the Inspector General determines that abuse or neglect is substantiated against an employee, the Inspector General shall note in the investigative report any aggravating or mitigating circumstances. The Inspector General shall provide a complete investigative report within 10 calendar days, to the Secretary, when abuse or neglect is substantiated or administrative action is recommended including a written response from a community agency or facility if one has been provided.

The facility or agency shall inform the victim and the legal guardian (if applicable) and the accused employee whether the reported allegation was substantiated, unsubstantiated or unfounded. If the authorized representative or designee is unable to reach the guardian by phone, a letter of notification shall be sent within 24 hours.

DRS administration is responsible to ensure that all services provided to participants are safe and adequate (Section 684.10 Service Plan), and is responsible for ensuring that all reports of unusual incidents (UIR) are processed in a timely and appropriate manner (DRS Unusual Incident Procedure).

Participants Age 60 and Older:

The DoA 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. The program is locally coordinated through 43 provider agencies designated by the Area Agencies on Aging (AAA) and DoA.

Timeframes depend on the classification/severity of each report. Each program has timeframes specific to type of report. DoAÃ‚Â's Office of Elder Rights maintains a tracking system of ANE investigations and statistical reports are generated annually.

For participants enrolled in an MCO, the Plans will have processes and procedures in place to receive reports of critical incidents. Critical events and incidents must be reported and identified issues routed to the appropriate department within the Plan and when indicated to the investigating authority described above. The procedures will include processes for ensuring participant safety while the State authority conducts its investigation.

State requirements for reporting of abuse, neglect or financial exploitation of participants ages 18 through 59 are as follows:

The OA DHS OIG, which is a semi-independent entity that reports to both the Governor and the OA, has statutory authority under the Adults with Disabilities Abuse Project, 59 Il. Admin. Code 51, to respond to allegations related to adults with disabilities ages of 18 through 59 who reside in domestic situations. Under the statute, DHS OIG has authority to investigate, take emergency action, work with local law enforcement authorities, obtain financial and medical records, and pursue guardianship. With the individual's consent, substantiated cases are referred to the OA for development of a service plan to meet identified needs.

The OA 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 OA determines that a case is substantiated, it shall refer the case to the appropriate office within the Department of Human Services to develop, with the consent of and in consultation with the adult with disabilities, a service plan for the adult with disabilities.

Anyone may make a report of alleged abuse, neglect or financial exploitation by calling the DHS Office of Inspector General 24-hour hotline: 1-800-368-1463 (voice and 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 respective Office of Inspector General is immediately contacted. Additionally, it is determined if immediate agency action is required as well. Any direction received from the respective Office of Inspector General is acted on immediately.

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 DHS-OIG 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 OIG 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 (A/N/E) investigator contacts appropriate field personnel to request follow up on an allegation, and requests 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 Office of Inspector General 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, the Office of Inspector General, 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 Office of Inspector General.

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; the Office of Inspector General; or the 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:

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

  i. **Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

  ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- ◉ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ○ **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

  i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

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

potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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

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

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

iii. Medication Error Reporting. *Select one of the following:*

- **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

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

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

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. **Sub-Assurances:**

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
42G: # and % of partcpts who received info from the OA and MCO about how and to whom to report abuse, neglect, exploitation at the time of assessment/reassessment. N: # of partcpt records reviewed where the partcpt received info from the OA and MCO about how and to whom to report abuse, neglect exploitation at the time of assessment/reassessment. D: Total # of OA and MCO partcpts recs reviewed.

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

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

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

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
43G: # 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:
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**	☑ **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:
44G: # and % of participants substantiated cases of abuse, neglect or exploitation recieved from DHS-OIG where the OA and MCO implemented the DHS-OIG recommendations. N: # of substantiated cases of A/N/E received from DHS-OIG where the OA and MCO implemented the DHS-OIG recommendations. D: Total # of substantiated cases of abuse, neglect or exploitation recieved by the OA and MCO from DHS-OIG.

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:
45G: # 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** Specify: MCO	☐ **Annually**	☐ **Stratified** 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 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:

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

Responsible Party for 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:
47G: # and % of participant satisfaction survey respondents who reported to the OA and MCO of being treated well by direct support staff. N: # of participant satisfaction survey respondents who reported to the OA and MCO of being treated well by direct support staff. D: Total # of OA and MCO participant satisfaction survey respondents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OA Reports: QA Satisfaction Surveys; POSM Survey question E.1.a.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: 10% of the population selected randomly by region
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
MCO Reports; POSM Survey question E.1.a.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
48G: # and % of partcpts for whom identified critical incidents other than A/N/E were reviewed and corrective measures were appropriately taken by the OA and MCO. N:# of partcpts for whom identified critical incidents other than A/N/E were reviewed and corrective measures were taken by the OA and MCO. D:Total # of OA and MCO partcpts for whom identified critical incidents were reviewed.

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

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

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

Data 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:
49G:# and % of OA and MCO participants who have personal assistants or other independently employed services whose service plan included back up plans. N: # of OA and MCO partcpts reviewed who have personal assistant or other indepen employed services whose service plan included back up plans. D: Total OA and MCO partcptss reviewed who have personal assistant or other independt 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 =

		+/-5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

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

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

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

Performance Measures

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Medicaid agency, 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.
42G: 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.

43G: 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.

44G: 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.

45G: The cause of death/circumstances would be reviewed by the OA and MCO and need for training or other remediation; including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns. Resolution or remediation timeframe would be case-specific.

46G: Restraint applications, seclusion, or other restrictive interventions will be reviewed by the OA and MCO. The need for training or other remediation; including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns. Resolution or remediation timeframe would be case-specific.

47G: 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.

48G: The OA and MCO will follow up on identified critical incidents, other than A/N/E, to ensure information was reviewed and corrective measures were appropriately taken. Resolution or remediation will be based on the nature of the concern. Survey responses will be used to identify need for system improvement.

49G: The OA and MCO would develop and implement PA back up plans and revisions to customers' service plans. Remediation must be completed within 30 days.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

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

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

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

The Illinois Department of Healthcare and Family Services, as the Single State Medicaid Agency (MA), and the Illinois Department of Human Services, Division of Rehabilitation Services (DHS-DRS), as the Operating Agency (OA), and the contracted Managed Care Organizations (MCOs) will work in partnership to evaluate the waiver Quality Management System (QMS) and to analyze the information derived from discovery and remediation activities for each of the federal assurances.

The OA and MCO's are responsible for the majority of the data collection to address the Quality Management System discovery and remediation activities. The OA is solely responsible for eligibility and authorizing qualified providers. Therefore, there are distinct performance measures for these functions under the

OA. Both the OA and the MCOs are accountable for all other measures. The MA is accountable for the measures in the Administrative Authority appendix. Additional measures have been added under the Administrative Authority appendix that are specific to oversight of the MCOs. The State's system improvement activities are in response to aggregated and analyzed discovery and remediation data collected on each of the waiver performance measures.

The persons with 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 or 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.

On a quarterly basis, the MA will conduct separate Quality Management Committee (QMC) meetings with the OA and the MCOs to review data collected from the previous quarter and for the year to date. Data to be collected semi-annually or annually will be reported as indicated by the performance measure in the waiver. All reports will be provided to MA for review prior to the quarterly meetings. Annual reports will be produced identifying trends based on the full representative sample and/or 100% review of data.

OA and MCO data will be reported by individual performance measures. The OA will also report on findings from the other two waivers under its umbrella, for comparison purposes. Individual performance measure reports will include: level of compliance and timeliness of remediation based on immediate, 30, 60, 90 day increments and any outstanding remediation. The MCOs will report in the same format as the OA.

During quarterly meetings, the MA and the OA or MCO will identify trends based on scope, severity, changes and patterns of compliance by reviewing both the levels of compliance with the performance measures and remediation activities conducted by the OA and the MCOs. Identified trends will be discussed and analyzed regarding cause, contributing factors and opportunities for system improvement. Systems improvement will be prioritized based on the overall impact to the participants and the program. Systems improvements may be prioritized based on factors such as: the impact on the health and welfare of waiver participants, legislative considerations and fiscal considerations. The OA and the MCOs will maintain separate QMC Systems Improvement Logs. Recommendations for system improvements will be added to the log(s) for tracking purposes. The OA and the MCOs will document the systems improvement implementation activities on its respective log. The MA will assure that the recommendations are followed through to completion. Decisions and time lines for system improvement will be made based on consensus of priority and specific steps needed to accomplish change. These decisions will be documented on the systems improvement log and will be communicated through the sharing of the quarterly meeting summary and the systems improvement log.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☐ **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 will provide an arena to see the system holistically and determine how well the system design changes are working and what areas need further improvement. Decisions that are made as a result of these meetings will be tracked on the QMC Systems Improvement Log.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

One QMC meeting a year will be a combined meeting where the MA, the OA, and the MCOs will meet and discuss statewide issues impacting the waiver. During this annual meeting, the OA and the MCOs will provide an overview of the previous year's activities and a discussion of whether changes are needed to the Quality Management Strategy. There will be five primary focus areas: These areas are described below.
1)Structure of the QMC: The group will review the structure of the QMC to determine if it is effective.
2)Trend Analysis: The group will evaluate the processes for identifying trends and patterns to assure that issues are being identified.
3)Systems Improvement Log: The group will review the QMC Systems Improvement Log to assure that all recommendations have been implemented in accordance with agreed upon time lines, and if not, whether there is justification.
4)System Improvement Priorities: The methods for determining system improvement priorities will be evaluated to determine its effectiveness.
5)Performance Measures: The entities will determine whether to make changes in existing performance measures, add measures, or discontinue measures. Other elements of performance measures will also be reviewed for effectiveness, including: the frequency of data collection, source of data, sampling methodology, and remediation.

The State will continually strive to increase the compliance rate of each performance measure. While the target compliance rate for each performance measure is 100%, the State realizes that it may take multiple system changes over several years to reach the goal of 100% compliance.

Appendix 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.

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 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:
50I: # and % of payments that were paid using the correct rate as specified in the waiver application. N: # of OA payments to the OA and MCO using the correct rate as specified in the waiver application. D: Total # of OA and MCO payments.

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

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

	Semi-Annually	

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

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

Data Aggregation and Analysis:

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

	Semi-Annually

Performance Measure:
51I: # and % of payments that were paid for participants who were enrolled in the waiver on the date the service was delivered. N: # of payments to the OA and MCO that were paid for participants who were enrolled in the waiver on the date the service was delivered. D: Total # of OA and MCO payments.

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
52I: # and % of payments there 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

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
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.
50I:The MA will require that the OA to either recoup the overpayment or repay at correct rate. If necessary, will also adjust the federal claim. Remediation must be completed within 30 days. The MA will require the MCO to recoup the overpayment or repay at correct rate. Remediation must be completed within 30 days.

51I: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.

52I: The OA/MCO will determine whether the service was authorized. If authorized, the OA/MCO will revise customer service plan; If not authorized, the OA/MA will void the federal claims that were not consistent with service plans. Remediation must be completed within 30 days.

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

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

	Bi-annually

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

- (●) **No**
- ( ) **Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rate methodologies are developed by the Home Services Program within the Operating Agency (OA) with consultation and final approval by the Medicaid agency (MA). The Home Services Program is the umbrella program within the OA that oversees the three waivers operated by the OA (CMS control numbers 0142, 0202, and 0329). All waiver rates must be reviewed and approved by the MA, and are subject to public comment. The MA solicits public comments when changes in methods and standards for establishing payment rates under the waiver are proposed. The notice is published in accordance with the Federal requirements in 42 CFR 447.205, which prescribes the content and publication criteria for the notice. Copies of the rate notices are on file with HFS.

Rates of payment for program services since the initial 1915c waiver was approved in 1982 have been established as described below:

Personal Assistant (PA): Until July 2003, PAs were paid Il. minimum wage as required by state statute and as formally established by the General Assembly (GA)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 signed Executive Order 2003-8 requiring an election to determine labor representation of PAs. SEIU became the exclusive bargaining unit for all PAs. The agreement indicates that hourly PA rates receive periodic flat rate adjustments. 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 Il. Central Management Services website. The labor agreement is posted on the OA's website under the HSP. The agreements are signed every 3-4 years, but within the limits of the Governor's term.

Home Health (HH) rates (Extended State Plan and "Other") are available to the public through the OA's website under HSP and the MA's website on the HH fee schedule.

HH Extended State Plan Services: Includes: RN, LPN, intermittent nurses HH aides (CNA) and therapists (OT, speech, PT). See below:

Intermittent Nursing agency providers are paid an all-inclusive rate the lowest of (on or after July 1, 2002):
1)the provider's usual and customary charge to the general public for the service.
2)the provider's Medicare rate
3)MA's fee schedule rate set as of 07/01/12, and effective for services provided on or after that date.

HH Aide (CNA) agency rates are based on the Private Duty Nursing (PDN) services rates in the State Plan (SP) that indicates that "In-home shift nursing payments for children who are under 21 years of age shall be at the MAs

established hourly rate to an agency licensed to provide these services". For children under 21, there is a geographic differential for these rates. For adults in the waiver, a statewide rate is used.

HH Aide (CNA) independent rates are negotiated between the participants and the providers. Negotiated rates cannot exceed the rates on the OA and MA fee-schedule. The OA pays the lesser of provider's charges, Medicare rate, or the MA fee-schedule.

Speech, OT, and PT agency/independent rates:
Base rates are established by the SP as follows: Lesser of the usual and customary charge to the general public or statewide maximums established by the MA not to exceed the upper limits specified in federal regulations. Reimbursement is based upon the applicable modifier billed by the provider, and will be either for the technical component, the professional component or a global amount.

HH Providers for "Other Services":
This includes in-home shift nursing.

In-home Shift Nursing agency rates are based on the PDN rates in the SP that indicates that "In-home shift nursing payments for children who are under 21, shall be at the MAs established hourly rate to an agency licensed to provide these services". For children under 21, there is a geographic differential for these rates. For adults in the waiver, a statewide rate is used.

In-home Shift Nursing independent rates are negotiated between the participants and the providers. Negotiated rates cannot exceed the rates on the OA and MA fee-schedules. The OA pays the lesser of provider's charges, Medicare rate, or the MA fee-schedule.

Homemaker (HM) fixed unit rates are based on the rates established by IDoA. To establish the initial rate in the original joint 1982 IDoA/HSP waiver, IDoA employed a RFP process where applicants indicated their costs for providing the service and the size of the population each applicant projected it could serve. The rate was then established at one standard deviation above the mean of the weighted costs received. Subsequent rates added COLA to the previous rate or through rates agreed upon between the State and SEIU. Effective 07/01/08, a 3 year agreement raised the HM rate to coincide with the three-step increase in the federal Fair Minimum Wage Act of 2007.

The HM rates include administrative costs and direct care staff wages. Rule, 89 Illinois Administrative Code, Part 240-Section 2040, provides that HM agencies must expend a minimum of 77% of the total revenues on the direct service worker. They are not geographically based and do not include room and board. Effective 07/01/08, the rate was enhanced to cover health insurance costs under PA 95-713. Total revenue does not include any amount received as an enhanced rate for health insurance costs by a provider.

HM rates are reviewed annually and adjustments are made to conform to the Community Care Program's (CCP) appropriation and to program service requirements and Federal and State changes in statutes and rules affecting the CCP. In establishing fixed unit rates of reimbursement, IDoA takes into consideration the following: 1) service utilization and cost information; 2) current market conditions and trend analyses; and 3) CCP budgetary cost assumptions and enacted appropriation. HM rates are formalized by the GA in IDoA's enabling legislation (20 ILCS 105/4.02).), and through the annual appropriations budget process. The rates are available to the public through the OA's website under HSP.

Adult Care Day Service (ADS) rates are based on rates established by the IDoA. The fee-for-service reimbursement rate structure consists of two fixed unit rates, one for ADS and another for transportation. The initial unit rate for ADS was established as 5 direct client contact hrs per day (excluding transportation). In April 1996, IDoA changed the definition of an ADS unit to allow less than 5 hrs of ADS to be authorized. The ADS rates include both administrative and direct care costs. They are not geographically based and do not include room and board.

The fixed unit rates are reviewed annually and adjustments are made to conform to the CCP appropriation and to program service requirements and Federal and State changes in statutes and rules affecting the CCP. In establishing fixed unit rates of reimbursement, IDoA takes into consideration the following: 1) service utilization and cost information; 2) current market conditions and trend analyses; and 3) CCP budgetary cost assumptions and enacted appropriation.

Subsequent rates are determined by adding negotiated COLA increases to the previous rates, which have been formalized by the GA in IDoA's enabling legislation (20 ILCS 105/4.02).), and through the annual appropriations

budget process. The rates are available to the public through the OA's website under HSP.

Emergency Home Response (EHR) rates are based on the rates established by IDoA. The fixed unit rates were established in 2007, pursuant to a RFI process. Payment includes a one-time installation fee and a separate monthly rate for ongoing EHR services. The rate covers the following: maintaining adequate local staffing levels of personnel, installation, training, signal monitoring, technical support and repairs. Rates are not geographically based and do not include room and board. In establishing fixed unit rates of reimbursement, IDoA takes into consideration the following: 1) service utilization and cost information; 2) current market conditions and trend analyses; and 3) CCP budgetary cost assumptions and enacted appropriation.

The fixed unit rates are reviewed and adjustments are made when negotiated and approved as part of the annual CCP appropriation process; and to conform to applicable Federal and State changes in statutes and rules affecting the CCP. The rates are available to the public through the OA's website under HSP.

Home Delivered Meals (HDM) rates are established by the OA. The administrative rule (89 Il Admin, Part 686.510) specifies that the rates can be no more than what it would cost for a PA to prepare a meal. The rates are not geographically-based and do not include direct or indirect administrative costs. As part of the budget process, rate adjustments are made to conform to appropriations and to program service requirements and Federal and State changes in statutes and rules affecting the HCBS Waivers. 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 a particular 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. 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 3 bids cannot be obtained or a bid is the sole source for lack of available vendors, a formal justification is required to pay the higher amount. Rates are published on the OA's website under HSP.

Managed Care Rates
Capitated rates for waiver services implemented through MCOs were developed by the state's contracted actuary by analyzing historical waiver data information including: enrollment, utilization and paid claims. This information was converted to a Per Participant per Month (PPPM) basis and stratified by waiver service. The capitated rate for MCOs is a flat monthly rate, and is in compliance with 42 CFR 438.6.

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.

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**
- [x] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

The operating agency receives the non-federal share through the General Revenue Fund appropriations.

- [ ] **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

Check each that applies:

- [ ] **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- [ ] **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

  Check each that applies:
  - [ ] **Health care-related taxes or fees**
  - [ ] **Provider-related donations**
  - [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ( ) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ( ) **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D**

(cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. **Co-Payment Requirements.**

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1		7418.58	7418.58	24670.64	12473.95	37144.59	29726.01
2		7576.45	7576.45	25653.42	12934.03	38587.45	31011.00
3		7737.67	7737.67	26675.36	13411.07	40086.43	32348.76
4		7902.33	7902.33	26675.36	13905.72	40581.08	32678.75
5		8070.49	8070.49	28842.99	14418.60	43261.59	35191.10

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	30300	30300
Year 2	31593	31593
Year 3	33489	33489
Year 4	35498	35498
Year 5	37728	37728

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 10/01/02 (years four and five of the previous renewal and years one, two, and three of the current waiver.)

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:

Data from an analysis of actual Factor D costs and utilization for prior years was not averaged because significant changes in hourly rates produced significant utilization changes. As a result, data from the most recent year was used with projected average growth applied. Since the state's FY10 budget has not been finalized, growth was based on prior history of total spending and then Medicaid claim utilization.

Fee-for-service Population:
We have assumed that the unique number of users by waiver service and the cost per unit would remain the same. We have calculated the units per user by maintaining the same aggregate number of units in both the fee-for-service and MCO populations, as compared with the current waiver Factor D calculation.

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.

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:

Projected Health Care Costs for Ancillary service were obtained from the Healthcare Cost Review quarterly report which currently shows a nationwide projected increase in health care cost of 2.128%.

The capitation rate for waiver participants enrolled in Managed Care Organization will include both waiver services, as identified in Factor D, and ancillary medical and pharmacy services. The capitation rate will be certified as actuarially sound. The capitation rate will be developed based on historical fee-for-service costs for ancillary services for waiver recipients from state fiscal years 2008 through 2011. The historical ancillary service expenditures will be trended forward to the contract rating years. Further, adjustments will be applied for policy and program changes, as well as anticipated managed care impact adjustments. The capitation rate will also include an administrative and risk load appropriate for the MCO.
Since not all waiver recipients are enrolled in an MCO, Factor D' will be developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is the institutional cost per person for those individuals with disabilities. Factor G is estimated to increase by 3.98% each year for WY'10 - WY'14 due to utilization. The 3.98% 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 will be certified as actuarially sound. The capitation rate will be developed based on historical fee-for-service nursing facility costs from state fiscal years (SFY) 2008 through 2011. The historical nursing facility experience will be trended forward to the contract rating years. Further, adjustments will be applied for policy and program changes, as well as anticipated managed care impact adjustments. The capitation rate will also include an administrative and risk load appropriate for the MCO.
Since not all nursing facility residents are enrolled in an MCO, Factor G will be developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G Prime is estimated to increase 3.69% for WY'10 - WY'14. This percentage is based upon the average historical percent change for WY'03 - WY'08. Actual ancillary expenditures per capita for Institutional residents and carried forward to WY'10 - WRY'14. These estimates include case mix and rate increases.

The capitation rate nursing facility residents enrolled in Managed Care Organization will include both nursing facility services, as identified in Factor G, and ancillary medical and pharmacy services. The capitation rate will be certified as actuarially sound. The capitation rate will be developed based on historical fee-for-service costs for ancillary services for nursing facility residents from state fiscal years 2008 through 2011. The historical ancillary service expenditures will be trended forward to the contract rating years. Further, adjustments will be applied for policy and program changes, as well as anticipated managed care impact adjustments. The capitation rate will also include an administrative and risk load appropriate for the MCO.
Since not all nursing home residents are enrolled in an MCO, Factor G' will be developed based on a blend of those remaining in fee-for-service and those enrolling in an MCO.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services

Adult Day Care
Homemaker
Personal Assistant
Respite
Home Health Aide
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:							**1582980.92**
Adult Day Care	☐	Day	226	621.00	9.02	**1265920.92**	
Adult Day Care Transport	☐	Day	191	200.00	8.30	**317060.00**	
Adult Day Care Capitated	☑	Day	0	0.00	9.02	**0.00**	
Adult Day Care Transport Capitated	☑	Day	0	0.00	8.30	**0.00**	
Adult Day Care MMAI	☑	Day	0	0.00	0.01	**0.00**	
Adult Day Care Transport MMAI	☑	Day	0	0.00	0.01	**0.00**	
Adult Day Care MMAI Opt Out	☑	Day	0	0.00	0.01	**0.00**	
Adult Day Care Transport MMAI Opt Out	☑	Day	0	0.00	0.01	**0.00**	
Homemaker Total:							**38084171.84**
Homemaker	☐	Hour	4346	572.00	15.32	**38084171.84**	
Homemaker						**0.00**	

Capitated	✓	Hour	0	0.00	15.32		
Homemaker MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Homemaker MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Personal Assistant Total:							**329724000.00**
Personal Assistant		Hour	24424	1200.00	11.25	**329724000.00**	
Personal Assistant Capitated	✓	Hour	0	0.00	11.25	**0.00**	
Personal Assistant MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Personal Assistant MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Respite Total:							**1091744.79**
RN		Hour	11	321.00	28.09	**99185.79**	
Adult Day Care		Day	1	6.00	9.02	**54.12**	
Homemaker		Hour	20	120.00	15.32	**36768.00**	
LPN		Hour	12	186.00	22.14	**49416.48**	
Personal Assistant		Hour	454	172.00	11.25	**878490.00**	
Home Health Aide		Hour	20	104.00	13.38	**27830.40**	
RN Capitated	✓	Hour	0	0.00	28.09	**0.00**	
Adult Day Care Capitated	✓	Day	0	0.00	9.02	**0.00**	
Homemaker Capitated	✓	Hour	0	0.00	15.32	**0.00**	
LPN Capitated	✓	Hour	0	0.00	22.14	**0.00**	
Personal Assistant Capitated	✓	Hour	0	0.00	11.25	**0.00**	
Home Health Aide Capitated	✓	Hour	0	0.00	13.38	**0.00**	
RN MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Adult Day Care MMAI	✓	Day	0	0.00	0.01	**0.00**	
Homemaker MMAI	✓	Hour	0	0.00	0.01	**0.00**	
LPN MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Personal Assistant MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Home Health Aide MMAI	✓	Hour	0	0.00	0.01	**0.00**	
RN MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Adult Day Care MMAI Opt Out	✓	Day	0	0.00	0.01	**0.00**	
Homemaker MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
LPN MMAI Opt							

Out	✓	Hour	0	0.00	0.01	**0.00**	
Personal Assistant MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Home Health Aide MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Home Health Aide Total:							**8200893.80**
Home Health Aide		Hour	943	670.00	12.98	**8200893.80**	
Home Health Aide Capitated	✓	Hour	0	0.00	12.98	**0.00**	
Home Health Aide MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Home Health Aide MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Occupational Therapy Total:							**17205.00**
Occupational Therapy		Hour	31	15.00	37.00	**17205.00**	
Occupational Therapy Capitated	✓	Hour	0	0.00	37.00	**0.00**	
Occupational Therapy MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Occupational Therapy MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Physical Therapy Total:							**36556.00**
Physical Therapy		Hour	26	38.00	37.00	**36556.00**	
Physical Therapy Capitated	✓	Hour	0	0.00	37.00	**0.00**	
Physical Therapy MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Physical Therapy MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Speech Therapy Total:							**27972.00**
Speech Therapy		Hour	28	27.00	37.00	**27972.00**	
Speech Therapy Capitated	✓	Hour	0	0.00	37.00	**0.00**	
Speech Therapy MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Speech Therapy MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations Total:							**690744.60**
Environmental Accessibility Adaptations		Unit	195	1.00	3542.28	**690744.60**	
Environmental Accessibility Adaptations Capitated	✓	Unit	0	0.00	3542.28	**0.00**	
Environmental Accessibility Adaptations MMAI	✓	Hour	0	0.00	0.01	**0.00**	

Environmental Accessibility Adaptations MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Home Delivered Meals Total:							**4783800.00**
Home Delivered Meals		Day/week	2680	119.00	15.00	**4783800.00**	
Home Delivered Meals Capitated	✓	Day/week	0	0.00	15.00	**0.00**	
Home Delivered Meals MMAI	✓	Day/week	0	0.00	0.01	**0.00**	
Home Delivered Meals MMAI Opt Out	✓	Day/week	0	0.00	0.01	**0.00**	
In-Home Shift Nursing Total:							**3477188.16**
Multi-Customer Nurse		Hour	12	564.00	50.90	**344491.20**	
RN		Hour	81	552.00	28.58	**1277868.96**	
LPN		Hour	150	536.00	23.07	**1854828.00**	
Multi-Customer Nurse Capitated	✓	Hour	0	0.00	50.90	**0.00**	
RN Capitated	✓	Hour	0	0.00	28.58	**0.00**	
LPN Capitated	✓	Hour	0	0.00	23.07	**0.00**	
Multi-Customer Nurse MMAI	✓	Hour	0	0.00	0.01	**0.00**	
RN MMAI	✓	Hour	0	0.00	0.01	**0.00**	
LPN MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Multi-Customer Nurse MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
RN MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
LPN MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Intermittent Nursing Total:							**310329.00**
Intermittent Nursing		Hour	164	29.00	65.25	**310329.00**	
Intermittent Nursing Capitated	✓	Hour	0	0.00	65.25	**0.00**	
Intermittent Nursing MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Intermittent Nursing MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Personal Emergency Response System Total:							
Personal Emergency Response System Install		One time	1227	1.00	30.00	**36810.00**	
Personal Emergency Response System		Month	5452	9.00	28.00	**1373904.00**	

Personal Emergency Response System Install Capitated	✓	One time	0	0.00	30.00	**0.00**	
Personal Emergency Response System Capitated	✓	Month	0	0.00	28.00	**0.00**	
Personal Emergency Response System Install MMAI	✓	One time	0	0.00	0.01	**0.00**	
Personal Emergency Response System MMAI	✓	Month	0	0.00	0.01	**0.00**	
Personal Emergency Response System Install MMAI Opt Out	✓	One time	0	0.00	0.01	**0.00**	
Personal Emergency Response System MMAI Opt Out	✓	Month	0	0.00	0.01	**0.00**	
Personal Emergency Response System							
Specialized Medical Equipment Total:							**554741.52**
Specialized Medical Equipment		Unit	412	2.00	673.23	**554741.52**	
Specialized Medical Equipment Capitated	✓	Unit	0	0.00	673.23	**0.00**	
Specialized Medical Equipment MMAI	✓	Unit	0	0.00	0.01	**0.00**	
Specialized Medical Equipment MMAI Opt Out	✓	Unit	0	0.00	0.01	**0.00**	

GRAND TOTAL:	
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	389993041.63
Total Estimated Unduplicated Participants:	**30300**
Factor D (Divide total by number of participants):	
Services included in capitation:	0.00
Services not included in capitation:	12871.06
Average Length of Stay on the Waiver:	280

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:							**1750260.22**
Adult Day Care	☐	Day	239	621.00	9.02	**1338739.38**	
Adult Day Care Transport	☐	Day	202	200.00	8.30	**335320.00**	
Adult Day Care Capitated	☑	Day	0	0.00	9.02	**0.00**	
Adult Day Care Transport Capitated	☑	Day	0	0.00	8.30	**0.00**	
Adult Day Care MMAI	☑	Day	20	445.71	6.83	**60883.99**	
Adult Day Care Transport MMAI	☑	Day	17	143.47	6.28	**15316.86**	
Adult Day Care MMAI Opt Out	☑	Day	0	0.00	0.01	**0.00**	
Adult Day Care Transport MMAI Opt Out	☐	Day	0	0.00	0.01	**0.00**	
Homemaker Total:							**42372141.94**
Homemaker	☐	Hour	4606	572.00	15.32	**40362562.24**	
Homemaker Capitated	☑	Hour	0	0.00	15.32	**0.00**	
Homemaker MMAI	☑	Hour	378	409.58	12.98	**2009579.70**	
Homemaker MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Personal Assistant Total:							**390773815.64**
Personal Assistant	☐	Hour	25890	1200.00	12.06	**374680080.00**	
Personal Assistant Capitated	☑	Hour	0	0.00	12.06	**0.00**	
Personal Assistant MMAI	☑	Hour	2122	859.89	8.82	**16093735.64**	
Personal Assistant MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Respite Total:							**1206915.68**
RN	☐	Hour	11	321.00	28.09	**99185.79**	
Adult Day Care	☐	Day	1	6.00	9.02	**54.12**	
Homemaker	☐	Hour	21	120.00	15.32	**38606.40**	
LPN	☐	Hour	13	186.00	22.14	**53534.52**	
Personal Assistant	☐	Hour	482	172.00	11.25	**932670.00**	
Home Health Aide	☐	Hour	22	99.00	13.39	**29163.42**	
RN Capitated	☑	Hour	0	0.00	28.09	**0.00**	
Adult Day Care Capitated	☑	Day	0	0.00	9.02	**0.00**	

Homemaker Capitated	✓	Hour	0	0.00	15.32	**0.00**	
LPN Capitated	✓	Hour	0	0.00	22.14	**0.00**	
Personal Assistant Capitated	✓	Hour	0	0.00	11.25	**0.00**	
Home Health Aide Capitated	✓	Hour	0	0.00	13.39	**0.00**	
RN MMAI	✓	Hour	1	238.33	21.77	**5188.44**	
Adult Day Care MMAI	✓	Day	1	4.67	9.02	**42.12**	
Homemaker MMAI	✓	Hour	2	84.48	12.98	**2193.10**	
LPN MMAI	✓	Hour	1	129.50	18.76	**2429.42**	
Personal Assistant MMAI		Hour	39	123.34	8.82	**42426.49**	
Home Health Aide MMAI	✓	Hour	2	70.18	10.13	**1421.85**	
RN MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Adult Day Care MMAI Opt Out	✓	Day	0	0.00	0.01	**0.00**	
Homemaker MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
LPN MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Personal Assistant MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Home Health Aide MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Home Health Aide Total:							**9086985.69**
Home Health Aide		Hour	999	670.00	12.98	**8687903.40**	
Home Health Aide Capitated	✓	Hour	0	0.00	12.98	**0.00**	
Home Health Aide MMAI	✓	Hour	82	480.44	10.13	**399082.29**	
Home Health Aide MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Occupational Therapy Total:							**19195.77**
Occupational Therapy		Hour	33	15.00	37.00	**18315.00**	
Occupational Therapy Capitated	✓	Hour	0	0.00	37.00	**0.00**	
Occupational Therapy MMAI	✓	Hour	3	10.77	27.26	**880.77**	
Occupational Therapy MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Physical Therapy Total:							**39482.02**
Physical Therapy		Hour	27	38.00	37.00	**37962.00**	
Physical Therapy Capitated	✓	Hour	0	0.00	37.00	**0.00**	

Physical Therapy MMAI	✓	Hour	2	27.88	27.26	**1520.02**	
Physical Therapy MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Speech Therapy Total:							**29676.53**
Speech Therapy		Hour	31	25.00	37.00	**28675.00**	
Speech Therapy Capitated	✓	Hour	0	0.00	37.00	**0.00**	
Speech Therapy MMAI	✓	Hour	2	18.37	27.26	**1001.53**	
Speech Therapy MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations Total:							**760608.05**
Environmental Accessibility Adaptations		Unit	207	1.00	3542.28	**733251.96**	
Environmental Accessibility Adaptations Capitated	✓	Unit	0	0.00	3542.28	**0.00**	
Environmental Accessibility Adaptations MMAI	✓	Hour	17	0.60	2681.97	**27356.09**	
Environmental Accessibility Adaptations MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Home Delivered Meals Total:							**5296275.68**
Home Delivered Meals		Day/week	2841	119.00	15.00	**5071185.00**	
Home Delivered Meals Capitated	✓	Day/week	0	0.00	15.00	**0.00**	
Home Delivered Meals MMAI	✓	Day/week	233	85.04	11.36	**225090.68**	
Home Delivered Meals MMAI Opt Out	✓	Day/week	0	0.00	0.01	**0.00**	
In-Home Shift Nursing Total:							**3838862.68**
Multi-Customer Nurse		Hour	12	564.00	50.90	**344491.20**	
RN		Hour	85	559.00	28.58	**1357978.70**	
LPN		Hour	159	536.00	23.07	**1966117.68**	
Multi-Customer Nurse Capitated	✓	Hour	0	0.00	50.90	**0.00**	
RN Capitated	✓	Hour	0	0.00	28.58	**0.00**	
LPN Capitated	✓	Hour	0	0.00	23.07	**0.00**	
Multi-Customer Nurse MMAI	✓	Hour	1	390.00	38.54	**15030.60**	
RN MMAI	✓	Hour	7	402.27	21.77	**61301.93**	
LPN MMAI	✓	Hour	13	385.20	18.76	**93942.58**	
Multi-Customer							

Nurse MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
RN MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
LPN MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Intermittent Nursing Total:							**342145.11**
Intermittent Nursing		Hour	174	29.00	65.25	**329251.50**	
Intermittent Nursing Capitated	✓	Hour	0	0.00	65.25	**0.00**	
Intermittent Nursing MMAI	✓	Hour	14	20.38	45.19	**12893.61**	
Intermittent Nursing MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Personal Emergency Response System Total:							
Personal Emergency Response System Install		One time	1300	1.00	30.00	**39000.00**	
Personal Emergency Response System		Month	5779	9.00	28.00	**1456308.00**	
Personal Emergency Response System Install Capitated	✓	One time	0	0.00	30.00	**0.00**	
Personal Emergency Response System Capitated	✓	Month	0	0.00	28.00	**0.00**	
Personal Emergency Response System Install MMAI	✓	One time	128	0.60	22.71	**1744.13**	
Personal Emergency Response System MMAI	✓	Month	474	5.99	21.20	**60192.31**	
Personal Emergency Response System Install MMAI Opt Out	✓	One time	0	0.00	0.01	**0.00**	
Personal Emergency Response System MMAI Opt Out	✓	Month	0	0.00	0.01	**0.00**	
Personal Emergency Response System							
Specialized Medical Equipment Total:							**609076.46**
Specialized Medical Equipment		Unit	436	2.00	673.23	**587056.56**	
Specialized Medical Equipment Capitated	✓	Unit	0	0.00	673.23	**0.00**	
Specialized Medical Equipment MMAI	✓	Unit	36	1.20	509.72	**22019.90**	

Specialized Medical Equipment MMAI Opt Out	✓	Unit	0	0.00	0.01	**0.00**	

GRAND TOTAL:	
Total: Services included in capitation:	19112847.55
Total: Services not included in capitation:	438569838.36
Total Estimated Unduplicated Participants:	**31593**
Factor D (Divide total by number of participants):	
Services included in capitation:	604.97
Services not included in capitation:	13881.87
Average Length of Stay on the Waiver:	280

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:							**1779660.68**
Adult Day Care		Day	254	621.00	9.02	**1422760.68**	
Adult Day Care Transport		Day	215	200.00	8.30	**356900.00**	
Adult Day Care Capitated	✓	Day	0	0.00	9.02	**0.00**	
Adult Day Care Transport Capitated	✓	Day	0	0.00	8.30	**0.00**	
Adult Day Care MMAI	✓	Day	0	0.00	0.01	**0.00**	
Adult Day Care Transport MMAI	✓	Day	0	0.00	0.01	**0.00**	
Adult Day Care MMAI Opt Out	✓	Day	0	0.00	0.01	**0.00**	
Adult Day Care Transport MMAI Opt Out	✓	Day	0	0.00	0.01	**0.00**	
Homemaker Total:							**42789924.32**
Homemaker		Hour	4883	572.00	15.32	**42789924.32**	
Homemaker Capitated	✓	Hour	0	0.00	15.32	**0.00**	
Homemaker MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Homemaker MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Personal Assistant Total:							**409339788.00**

Personal Assistant	☐	Hour	27443	1200.00	12.43	**409339788.00**	
Personal Assistant Capitated	☑	Hour	0	0.00	12.43	**0.00**	
Personal Assistant MMAI	☑	Hour	0	0.00	0.01	**0.00**	
Personal Assistant MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Respite Total:							**1225628.19**
RN	☐	Hour	12	321.00	28.09	**108202.68**	
Adult Day Care	☐	Day	1	6.00	9.02	**54.12**	
Homemaker	☐	Hour	22	120.00	15.32	**40444.80**	
LPN	☐	Hour	14	186.00	22.14	**57652.56**	
Personal Assistant	☐	Hour	511	172.00	11.25	**988785.00**	
Home Health Aide	☐	Hour	23	99.00	13.39	**30489.03**	
RN Capitated	☑	Hour	0	0.00	28.09	**0.00**	
Adult Day Care Capitated	☑	Day	0	0.00	9.02	**0.00**	
Homemaker Capitated	☑	Hour	0	0.00	15.32	**0.00**	
LPN Capitated	☑	Hour	0	0.00	22.14	**0.00**	
Personal Assistant Capitated	☑	Hour	0	0.00	11.25	**0.00**	
Home Health Aide Capitated	☑	Hour	0	0.00	13.39	**0.00**	
RN MMAI	☑	Hour	0	0.00	0.01	**0.00**	
Adult Day Care MMAI	☑	Day	0	0.00	0.01	**0.00**	
Homemaker MMAI	☑	Hour	0	0.00	0.01	**0.00**	
LPN MMAI	☑	Hour	0	0.00	0.01	**0.00**	
Personal Assistant MMAI	☑	Hour	0	0.00	0.01	**0.00**	
Home Health Aide MMAI	☑	Hour	0	0.00	0.01	**0.00**	
RN MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Adult Day Care MMAI Opt Out	☑	Day	0	0.00	0.01	**0.00**	
Homemaker MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
LPN MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Personal Assistant MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Home Health Aide MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Home Health Aide							

Total:							**9209699.40**
Home Health Aide	☐	Hour	1059	670.00	12.98	**9209699.40**	
Home Health Aide Capitated	☑	Hour	0	0.00	12.98	**0.00**	
Home Health Aide MMAI	☑	Hour	0	0.00	0.01	**0.00**	
Home Health Aide MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Occupational Therapy Total:							**19425.00**
Occupational Therapy	☐	Hour	35	15.00	37.00	**19425.00**	
Occupational Therapy Capitated	☑	Hour	0	0.00	37.00	**0.00**	
Occupational Therapy MMAI	☑	Hour	0	0.00	0.01	**0.00**	
Occupational Therapy MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Physical Therapy Total:							**40774.00**
Physical Therapy	☐	Hour	29	38.00	37.00	**40774.00**	
Physical Therapy Capitated	☑	Hour	0	0.00	37.00	**0.00**	
Physical Therapy MMAI	☑	Hour	0	0.00	0.01	**0.00**	
Physical Therapy MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Speech Therapy Total:							**30784.00**
Speech Therapy	☐	Hour	32	26.00	37.00	**30784.00**	
Speech Therapy Capitated	☑	Hour	0	0.00	37.00	**0.00**	
Speech Therapy MMAI	☑	Hour	0	0.00	0.01	**0.00**	
Speech Therapy MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations Total:							**779301.60**
Environmental Accessibility Adaptations	☐	Unit	220	1.00	3542.28	**779301.60**	
Environmental Accessibility Adaptations Capitated	☑	Unit	0	0.00	3542.28	**0.00**	
Environmental Accessibility Adaptations MMAI	☑	Hour	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Home Delivered Meals Total:							**5374635.00**
Home Delivered Meals	☐	Day/week	3011	119.00	15.00	**5374635.00**	

Home Delivered Meals Capitated	✓	Day/week	0	0.00	15.00	**0.00**	
Home Delivered Meals MMAI	✓	Day/week	0	0.00	0.01	**0.00**	
Home Delivered Meals MMAI Opt Out	✓	Day/week	0	0.00	0.01	**0.00**	
In-Home Shift Nursing Total:							**3900831.48**
Multi-Customer Nurse		Hour	13	564.00	50.90	**373198.80**	
RN		Hour	90	559.00	28.58	**1437859.80**	
LPN		Hour	169	536.00	23.07	**2089772.88**	
Multi-Customer Nurse Capitated	✓	Hour	0	0.00	50.90	**0.00**	
RN Capitated	✓	Hour	0	0.00	28.58	**0.00**	
LPN Capitated	✓	Hour	0	0.00	23.07	**0.00**	
Multi-Customer Nurse MMAI	✓	Hour	0	0.00	0.01	**0.00**	
RN MMAI	✓	Hour	0	0.00	0.01	**0.00**	
LPN MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Multi-Customer Nurse MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
RN MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
LPN MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Intermittent Nursing Total:							**350066.25**
Intermittent Nursing		Hour	185	29.00	65.25	**350066.25**	
Intermittent Nursing Capitated	✓	Hour	0	0.00	65.25	**0.00**	
Intermittent Nursing MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Intermittent Nursing MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Personal Emergency Response System Total:							
Personal Emergency Response System Install		One time	1379	1.00	30.00	**41370.00**	
Personal Emergency Response System		Month	6125	9.00	28.00	**1543500.00**	
Personal Emergency Response System Install Capitated	✓	One time	0	0.00	30.00	**0.00**	
Personal Emergency Response System Capitated	✓	Month	0	0.00	28.00	**0.00**	

Personal Emergency Response System Install MMAI	✓	One time	0	0.00	0.01	**0.00**	
Personal Emergency Response System MMAI	✓	Month	0	0.00	0.01	**0.00**	
Personal Emergency Response System Install MMAI Opt Out	✓	One time	0	0.00	0.01	**0.00**	
Personal Emergency Response System MMAI Opt Out	✓	Month	0	0.00	0.01	**0.00**	
Personal Emergency Response System							
Specialized Medical Equipment Total:							**622064.52**
Specialized Medical Equipment		Unit	462	2.00	673.23	**622064.52**	
Specialized Medical Equipment Capitated	✓	Unit	0	0.00	673.23	**0.00**	
Specialized Medical Equipment MMAI	✓	Unit	0	0.00	0.01	**0.00**	
Specialized Medical Equipment MMAI Opt Out	✓	Unit	0	0.00	0.01	**0.00**	

GRAND TOTAL:	
Total: Services included in capitation:	0.00
Total: Services not included in capitation:	477047452.44
Total Estimated Unduplicated Participants:	**33489**
Factor D (Divide total by number of participants):	
Services included in capitation:	0.00
Services not included in capitation:	14244.90
Average Length of Stay on the Waiver:	280

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:							**1899110.53**

Adult Day Care	☐	Day	269	574.83	9.02	**1394756.02**	
Adult Day Care Transport	☐	Day	228	185.09	8.30	**350264.32**	
Adult Day Care Capitated	☑	Day	20	621.00	9.91	**123082.20**	
Adult Day Care Transport Capitated	☑	Day	17	200.00	9.12	**31008.00**	
Adult Day Care MMAI	☑	Day	0	0.00	0.01	**0.00**	
Adult Day Care Transport MMAI	☑	Day	0	0.00	0.01	**0.00**	
Adult Day Care MMAI Opt Out	☑	Day	0	0.00	0.01	**0.00**	
Adult Day Care Transport MMAI Opt Out	☑	Day	0	0.00	0.01	**0.00**	
Homemaker Total:							**45695580.96**
Homemaker	☐	Hour	5176	529.01	15.32	**41948546.24**	
Homemaker Capitated	☑	Hour	389	572.00	16.84	**3747034.72**	
Homemaker MMAI	☑	Hour	0	0.00	0.01	**0.00**	
Homemaker MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Personal Assistant Total:							**408723731.31**
Personal Assistant	☐	Hour	29090	1109.78	11.55	**372874427.31**	
Personal Assistant Capitated	☑	Hour	2187	1200.00	13.66	**35849304.00**	
Personal Assistant MMAI	☑	Hour	0	0.00	0.01	**0.00**	
Personal Assistant MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Respite Total:							**1335504.75**
RN	☐	Hour	13	296.31	28.09	**108203.52**	
Adult Day Care	☐	Day	1	6.00	9.02	**54.12**	
Homemaker	☐	Hour	23	109.57	15.32	**38608.09**	
LPN	☐	Hour	15	173.60	22.14	**57652.56**	
Personal Assistant	☐	Hour	541	158.96	11.55	**993269.51**	
Home Health Aide	☐	Hour	24	90.75	13.39	**29163.42**	
RN Capitated	☑	Hour	1	321.00	30.87	**9909.27**	
Adult Day Care Capitated	☑	Day	0	0.00	9.02	**0.00**	
Homemaker Capitated	☑	Hour	2	120.00	16.84	**4041.60**	
LPN Capitated	☑	Hour	1	186.00	24.33	**4525.38**	
Personal Assistant Capitated	☑	Hour	41	172.00	12.36	**87162.72**	

Home Health Aide Capitated	✓	Hour	2	99.00	14.72	**2914.56**	
RN MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Adult Day Care MMAI	✓	Day	0	0.00	0.01	**0.00**	
Homemaker MMAI	✓	Hour	0	0.00	0.01	**0.00**	
LPN MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Personal Assistant MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Home Health Aide MMAI	✓	Hour	0	0.00	0.01	**0.00**	
RN MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Adult Day Care MMAI Opt Out	✓	Day	0	0.00	0.01	**0.00**	
Homemaker MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
LPN MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Personal Assistant MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Home Health Aide MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Home Health Aide Total:							**9838821.22**
Home Health Aide		Hour	1123	619.88	12.98	**9035705.62**	
Home Health Aide Capitated	✓	Hour	84	670.00	14.27	**803115.60**	
Home Health Aide MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Home Health Aide MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Occupational Therapy Total:							**20694.52**
Occupational Therapy		Hour	37	13.78	37.00	**18864.82**	
Occupational Therapy Capitated	✓	Hour	3	15.00	40.66	**1829.70**	
Occupational Therapy MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Occupational Therapy MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Physical Therapy Total:							**43866.01**
Physical Therapy		Hour	31	35.55	37.00	**40775.85**	
Physical Therapy Capitated	✓	Hour	2	38.00	40.66	**3090.16**	
Physical Therapy MMAI	✓	Hour	0	0.00	0.01	**0.00**	
Physical Therapy MMAI Opt Out	✓	Hour	0	0.00	0.01	**0.00**	
Speech Therapy Total:							**32998.66**

Speech Therapy	☐	Hour	34	23.71	37.00	**29827.18**	
Speech Therapy Capitated	☑	Hour	3	26.00	40.66	**3171.48**	
Speech Therapy MMAI	☑	Hour	0	0.00	0.01	**0.00**	
Speech Therapy MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations Total:							**829397.50**
Environmental Accessibility Adaptations	☐	Unit	233	0.92	3542.28	**759323.14**	
Environmental Accessibility Adaptations Capitated	☑	Unit	18	1.00	3893.02	**70074.36**	
Environmental Accessibility Adaptations MMAI	☑	Hour	0	0.00	0.01	**0.00**	
Environmental Accessibility Adaptations MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Home Delivered Meals Total:							**5740148.40**
Home Delivered Meals	☐	Day/week	3192	110.05	15.00	**5269194.00**	
Home Delivered Meals Capitated	☑	Day/week	240	119.00	16.49	**470954.40**	
Home Delivered Meals MMAI	☑	Day/week	0	0.00	0.01	**0.00**	
Home Delivered Meals MMAI Opt Out	☑	Day/week	0	0.00	0.01	**0.00**	
In-Home Shift Nursing Total:							**4178842.24**
Multi-Customer Nurse	☐	Hour	14	523.71	50.90	**373195.75**	
RN	☐	Hour	96	518.24	28.58	**1421884.72**	
LPN	☐	Hour	179	497.07	23.07	**2052665.48**	
Multi-Customer Nurse Capitated	☑	Hour	1	564.00	55.94	**31550.16**	
RN Capitated	☑	Hour	7	559.00	31.41	**122907.33**	
LPN Capitated	☑	Hour	13	536.00	25.35	**176638.80**	
Multi-Customer Nurse MMAI	☑	Hour	0	0.00	0.01	**0.00**	
RN MMAI	☑	Hour	0	0.00	0.01	**0.00**	
LPN MMAI	☑	Hour	0	0.00	0.01	**0.00**	
Multi-Customer Nurse MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
RN MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
LPN MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Intermittent							

Nursing Total:							**373683.27**
Intermittent Nursing	☐	Hour	196	26.78	65.25	**342489.42**	
Intermittent Nursing Capitated	☑	Hour	15	29.00	71.71	**31193.85**	
Intermittent Nursing MMAI	☑	Hour	0	0.00	0.01	**0.00**	
Intermittent Nursing MMAI Opt Out	☑	Hour	0	0.00	0.01	**0.00**	
Personal Emergency Response System Total:							
Personal Emergency Response System Install	☐	One time	1461	0.92	30.00	**40323.60**	
Personal Emergency Response System	☐	Month	6493	8.32	28.00	**1512609.28**	
Personal Emergency Response System Install Capitated	☑	One time	110	1.00	32.97	**3626.70**	
Personal Emergency Response System Capitated	☑	Month	488	9.00	30.77	**135141.84**	
Personal Emergency Response System Install MMAI	☑	One time	0	0.00	0.01	**0.00**	
Personal Emergency Response System MMAI	☑	Month	0	0.00	0.01	**0.00**	
Personal Emergency Response System Install MMAI Opt Out	☑	One time	0	0.00	0.01	**0.00**	
Personal Emergency Response System MMAI Opt Out	☑	Month	0	0.00	0.01	**0.00**	
Personal Emergency Response System	☐						
Specialized Medical Equipment Total:							**665034.85**
Specialized Medical Equipment	☐	Unit	490	1.85	673.23	**610283.00**	
Specialized Medical Equipment Capitated	☑	Unit	37	2.00	739.89	**54751.86**	
Specialized Medical Equipment MMAI	☑	Unit	0	0.00	0.01	**0.00**	
Specialized Medical Equipment MMAI Opt Out	☑	Unit	0	0.00	0.01	**0.00**	

GRAND TOTAL:

Total: Services included in capitation: 41767028.69

Total: Services not included in capitation: 439302086.95

Total Estimated Unduplicated Participants:	**35498**
Factor D (Divide total by number of participants):	
Services included in capitation:	1176.60
Services not included in capitation:	12375.40
Average Length of Stay on the Waiver:	280

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:							**2350257.28**
Adult Day Care	☐	Day	286	618.08	9.02	**1594473.34**	
Adult Day Care Transport	☐	Day	242	198.91	8.30	**399530.63**	
Adult Day Care Capitated	☑	Day	29	744.00	8.65	**186632.40**	
Adult Day Care Transport Capitated	☑	Day	25	240.00	7.96	**47760.00**	
Adult Day Care MMAI	☑	Day	20	445.71	6.83	**60883.99**	
Adult Day Care Transport MMAI	☑	Day	17	143.47	6.28	**15316.86**	
Adult Day Care MMAI Opt Out	☑	Day	13	424.93	6.61	**36514.23**	
Adult Day Care Transport MMAI Opt Out	☑	Day	11	136.75	6.08	**9145.84**	
Homemaker Total:							**63129016.90**
Homemaker	☐	Hour	5501	568.32	17.14	**53585267.40**	
Homemaker Capitated	☑	Hour	560	684.00	16.44	**6297177.60**	
Homemaker MMAI	☑	Hour	378	409.58	12.98	**2009579.70**	
Homemaker MMAI Opt Out	☑	Hour	252	390.82	12.56	**1236992.20**	
Personal Assistant Total:							**506324697.85**
Personal Assistant	☐	Hour	30917	1193.26	11.65	**429792026.24**	
Personal Assistant Capitated	☑	Hour	3147	1436.00	11.18	**50523448.56**	
Personal Assistant MMAI	☑	Hour	2122	859.89	8.82	**16093735.64**	

Personal Assistant MMAI Opt Out	✓	Hour	1415	820.54	8.54	**9915487.41**	
Respite Total:							**1689110.17**
RN		Hour	14	324.26	28.75	**130514.65**	
Adult Day Care		Day	1	7.00	9.02	**63.14**	
Homemaker		Hour	25	116.76	17.14	**50031.66**	
LPN		Hour	16	178.40	24.78	**70732.03**	
Personal Assistant		Hour	575	171.18	11.65	**1146692.02**	
Home Health Aide		Hour	26	97.31	13.38	**33852.20**	
RN Capitated	✓	Hour	1	385.00	27.58	**10618.30**	
Adult Day Care Capitated	✓	Day	0	7.00	9.02	**0.00**	
Homemaker Capitated	✓	Hour	3	144.00	16.44	**7102.08**	
LPN Capitated	✓	Hour	2	222.00	23.77	**10553.88**	
Personal Assistant Capitated	✓	Hour	59	206.00	11.18	**135881.72**	
Home Health Aide Capitated	✓	Hour	3	119.00	12.83	**4580.31**	
RN MMAI	✓	Hour	1	238.33	21.77	**5188.44**	
Adult Day Care MMAI	✓	Day	1	4.67	9.02	**42.12**	
Homemaker MMAI	✓	Hour	2	84.48	12.98	**2193.10**	
LPN MMAI	✓	Hour	1	129.50	18.76	**2429.42**	
Personal Assistant MMAI	✓	Hour	39	123.24	8.82	**42392.10**	
Home Health Aide MMAI	✓	Hour	2	70.18	10.13	**1421.85**	
RN MMAI Opt Out	✓	Hour	1	226.98	21.07	**4782.47**	
Adult Day Care MMAI Opt Out	✓	Day	0	4.67	9.02	**0.00**	
Homemaker MMAI Opt Out	✓	Hour	1	79.97	12.56	**1004.42**	
LPN MMAI Opt Out	✓	Hour	1	124.10	18.16	**2253.66**	
Personal Assistant MMAI Opt Out	✓	Hour	26	117.67	8.54	**26127.45**	
Home Health Aide MMAI Opt Out	✓	Hour	1	66.58	9.81	**653.15**	
Home Health Aide Total:							**12530371.27**
Home Health Aide		Hour	1193	666.50	13.38	**10638899.61**	
Home Health Aide Capitated	✓	Hour	121	802.00	12.83	**1245048.86**	
Home Health						**399082.29**	

Aide MMAI	✓	Hour	82	480.44	10.13		
Home Health Aide MMAI Opt Out	✓	Hour	55	458.42	9.81	**247340.51**	
Occupational Therapy Total:							**24685.34**
Occupational Therapy		Hour	39	14.80	36.00	**20779.20**	
Occupational Therapy Capitated	✓	Hour	4	18.00	34.53	**2486.16**	
Occupational Therapy MMAI	✓	Hour	3	10.77	27.26	**880.77**	
Occupational Therapy MMAI Opt Out	✓	Hour	2	10.22	26.38	**539.21**	
Physical Therapy Total:							**53446.37**
Physical Therapy		Hour	33	38.51	36.00	**45749.88**	
Physical Therapy Capitated	✓	Hour	3	46.00	34.53	**4765.14**	
Physical Therapy MMAI	✓	Hour	2	27.88	27.26	**1520.02**	
Physical Therapy MMAI Opt Out	✓	Hour	2	26.75	26.38	**1411.33**	
Speech Therapy Total:							**39329.38**
Speech Therapy		Hour	36	25.55	36.00	**33112.80**	
Speech Therapy Capitated	✓	Hour	4	31.00	34.53	**4281.72**	
Speech Therapy MMAI	✓	Hour	2	18.37	27.26	**1001.53**	
Speech Therapy MMAI Opt Out	✓	Hour	2	17.69	26.38	**933.32**	
Environmental Accessibility Adaptations Total:							**854784.59**
Environmental Accessibility Adaptations		Unit	247	0.83	3542.28	**726202.82**	
Environmental Accessibility Adaptations Capitated	✓	Unit	25	1.00	3397.92	**84948.00**	
Environmental Accessibility Adaptations MMAI	✓	Hour	17	0.60	2681.97	**27356.09**	
Environmental Accessibility Adaptations MMAI Opt Out	✓	Hour	11	0.57	2596.12	**16277.67**	
Home Delivered Meals Total:							**7072623.51**
Home Delivered Meals		Day/week	3392	118.01	15.00	**6004348.80**	
Home Delivered Meals Capitated	✓	Day/week	345	142.00	14.39	**704966.10**	
Home Delivered Meals MMAI	✓	Day/week	233	85.04	11.36	**225090.68**	
Home Delivered Meals MMAI Opt	✓	Day/week	155	81.14	10.99	**138217.93**	

Out							
In-Home Shift Nursing Total:							**5380603.38**
Multi-Customer Nurse	☐	Hour	15	534.16	50.90	**407831.16**	
RN	☐	Hour	102	556.99	28.75	**1633373.18**	
LPN	☐	Hour	190	534.03	24.78	**2514320.05**	
Multi-Customer Nurse Capitated	☑	Hour	2	675.00	48.83	**65920.50**	
RN Capitated	☑	Hour	10	669.00	27.58	**184510.20**	
LPN Capitated	☑	Hour	19	642.00	23.77	**289946.46**	
Multi-Customer Nurse MMAI	☑	Hour	1	390.00	38.54	**15030.60**	
RN MMAI	☑	Hour	7	402.27	21.77	**61301.93**	
LPN MMAI	☑	Hour	13	385.20	18.76	**93942.58**	
Multi-Customer Nurse MMAI Opt Out	☑	Hour	1	372.67	37.30	**13900.59**	
RN MMAI Opt Out	☑	Hour	5	383.87	21.07	**40440.70**	
LPN MMAI Opt Out	☑	Hour	9	367.63	18.16	**60085.45**	
Intermittent Nursing Total:							**413085.73**
Intermittent Nursing	☐	Hour	208	28.26	59.68	**350803.81**	
Intermittent Nursing Capitated	☑	Hour	21	34.00	57.25	**40876.50**	
Intermittent Nursing MMAI	☑	Hour	14	20.38	45.19	**12893.61**	
Intermittent Nursing MMAI Opt Out	☑	Hour	10	19.46	43.74	**8511.80**	
Personal Emergency Response System Total:							
Personal Emergency Response System Install	☐	One time	1859	0.83	30.00	**46289.10**	
Personal Emergency Response System	☐	Month	6901	8.31	28.00	**1605724.68**	
Personal Emergency Response System Install Capitated	☑	One time	189	1.00	28.78	**5439.42**	
Personal Emergency Response System Capitated	☑	Month	702	10.00	26.86	**188557.20**	
Personal Emergency Response System Install MMAI	☑	One time	128	0.60	22.71	**1744.13**	
Personal Emergency Response System	☑	Month	474	5.99	21.20	**60192.31**	

MMAI							
Personal Emergency Response System Install MMAI Opt Out	✓	One time	85	0.57	21.99	**1065.42**	
Personal Emergency Response System MMAI Opt Out	✓	Month	316	5.71	20.52	**37025.47**	
Personal Emergency Response System							
Specialized Medical Equipment Total:							**686223.04**
Specialized Medical Equipment		Unit	521	1.66	673.23	**582249.70**	
Specialized Medical Equipment Capitated	✓	Unit	53	2.00	645.79	**68453.74**	
Specialized Medical Equipment MMAI	✓	Unit	36	1.20	509.72	**22019.90**	
Specialized Medical Equipment MMAI Opt Out	✓	Unit	24	1.14	493.41	**13499.70**	

GRAND TOTAL:	
Total: Services included in capitation:	91081404.43
Total: Services not included in capitation:	511412868.11
Total Estimated Unduplicated Participants:	**37728**
Factor D (Divide total by number of participants):	
Services included in capitation:	2414.16
Services not included in capitation:	13555.26
Average Length of Stay on the Waiver:	280