

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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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

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- 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:**  
Illinois Supportive Living Program
- C. **Waiver Number:** IL.0326  
**Original Base Waiver Number:** IL.0326.90
- D. **Amendment Number:**
- E. **Proposed Effective Date:** (mm/dd/yy)

04/01/18

Approved Effective Date of Waiver being Amended: 10/23/17

### 2. Purpose(s) of Amendment

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

The IL Department of Healthcare and Family Services (HFS) is seeking to amend current 1915 (c) waivers to provide for statewide expansion of its mandatory managed care delivery system to all of Illinois' 102 counties. Illinois' mandatory managed care program, now called HealthChoice Illinois, will operate statewide offering providers the opportunity to contract with five managed care plans in all Illinois counties; seven managed care plans will be available in Cook County.

When fully operational, approximately 80% of all Illinois Medicaid beneficiaries will be enrolled in a HealthChoice Illinois plan. There are three rollout dates for HealthChoice Illinois:

- HealthChoice Illinois enrollments beginning January 1, 2018 includes members currently enrolled in a managed care plan. Beneficiaries enrolled in managed care prior to January 1, 2018 may remain with their plan if the plan is contracted to participate in HealthChoice Illinois; or they can select a new plan. If their health plan was not awarded a contract with HFS under HealthChoice Illinois, beneficiaries will have the opportunity to select a new plan.
- HealthChoice Illinois enrollments beginning April 1, 2018 includes beneficiaries residing in counties that were not previously mandatory to managed care.
- HealthChoice Illinois enrollments beginning July 1, 2018 will bring in populations newly eligible to mandatory managed care in Illinois. This will include special needs children such as children receiving Supplemental Security Income, children in the Medically Fragile Technology Dependent waiver and youth in care and former youth in care under the Illinois

Department of Children and Family Services.

The Integrated Care Program (ICP), Family Health Plan/ACA Adults FHP/ACA) and Managed Long Term Services and Supports (MLTSS) managed care programs are now incorporated in HealthChoice Illinois. Members enrolled in the Medicare Medicaid Alignment Initiative (MMAI) will not be impacted by HealthChoice Illinois. Illinois received approval from the federal Centers for Medicare and Medicaid Services (CMS) to jointly implement the MMAI program on February 22, 2013. Section 1915 (c) waivers impacted by MMAI were amended at that time.

#### 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. Home and Community Based Services (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 beneficiaries in the waiver will be the responsibility of the Plans. Plans bring resources to the programs that help more effectively coordinate community-based supports and services; plans consider the physical, mental and social needs of a member when coordinating care. The Plans have the staffing and information technology resources to connect and share information from the many providers that serve their members. 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 offer providers currently approved to provide waiver services. Plans are required to establish, maintain and monitor a provider network that is sufficient to provide adequate access to all covered services under the contract, including HCBS waiver services. 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 enrolled and remain active with HFS.

#### Service Plan Development

The Plans will be responsible for developing a comprehensive, person-centered Individualized Plan of Care (IPOC) for members enrolled in a Plan. This includes the development, implementation, monitoring, and updating of the plan when a member's needs change. The Plan care coordinator is charged with creating and maintaining the service plan, which is a component of the IPOC. The care coordinator and the member together develop a comprehensive, person-centered IPOC, with the member taking an active role in his or her short and long term treatment and service goals. The State will ensure that service plan development is conducted in the best interest of the member and will be based on individual preferences and assessed needs.

#### Transition of service plans

To provide a more seamless transition for members who are enrolled in the existing waiver, the Plans will maintain the current service plans for at least 90 days, unless changed with the consent and input of the member, and only after completion of a health screening and comprehensive needs assessment. If a member transitions to a new health plan, the new health plan must reach out to the former health plan and request that the IPOC, including service plan information, is sent. This is done in a secure format and shared electronically among plans when a transition occurs. Eligibility reassessments that come due during this 90-day transition will be conducted by the OA as described in the existing waiver.

#### Health Safety and Welfare Roles and Responsibilities

Along with the MA, the Plans will be responsible for the health, safety and welfare of the waiver member enrolled in the Plans. This will include monitoring the member to assure needs are being met. Plans must report and follow up on critical incidents. The Plans 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 member 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 members' needs are being met.

#### Quality Improvement Strategy (QIS)

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 fulfil the requirements of the American Recovery and Reinvestment Act of 2009 requirements for Indians, by:

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.

### 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)
<input checked="" type="checkbox"/> Waiver Application	Main, 1. 4
<input checked="" type="checkbox"/> Appendix A – Waiver Administration and Operation	3
<input type="checkbox"/> Appendix B – Participant Access and Eligibility	
<input checked="" type="checkbox"/> Appendix C – Participant Services	2.f.
<input type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	
<input type="checkbox"/> Appendix E – Participant Direction of Services	
<input type="checkbox"/> Appendix F – Participant Rights	
<input type="checkbox"/> Appendix G – Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input type="checkbox"/> Appendix I – Financial Accountability	
<input checked="" type="checkbox"/> 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 all of Illinois' 102 counties. Illinois' mandatory managed care program, now called HealthChoice Illinois, will operate statewide offering providers the opportunity to contract with five managed care plans in all Illinois counties; seven managed care plans will be available in Cook County.

## 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*):  
**Illinois Supportive Living Program**
- 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.0326

Draft ID: IL.005.04.01

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

Regular Waiver

- E. Proposed Effective Date of Waiver being Amended: 07/01/17  
 Approved Effective Date of Waiver being Amended: 10/23/17

### 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 in 42 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:

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

- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR

## §440.150)

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

## 1. Request Information (3 of 3)

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

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

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

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

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

A companion 1915(b) waiver was approved 5/28/14 with an expiration date of 5/31/19. Since this 1915(c) does not represent any substantive changes, no concurrent amendment to the 1915(b) is necessary at this time. The 1915(b) waiver states how Long Term Services and Supports (LTSS) that are defined in the 1915 (c) renewal are implemented.

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

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

§1915(b)(2) (central broker)

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

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

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

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

The Illinois IL.13-015 1932(a) State plan amendment (SPA) to implement mandatory managed care for the adult aged, blind and disabled populations in Cook County and surrounding border counties was approved for the effective date of May 1, 2011.

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

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

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

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

A program authorized under §1115 of the Act.

Specify the program:

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

### H. Dual Eligibility 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 IL Supportive Living Program (SLP) services (svcs). individuals (indiv.) ages 65 and older and persons with physical

<https://wms-mmdl.cms.gov/WMS/faces/protected/35/print/PrintSelector.isp>

3/1/2018

disab. ages 22-64 who are in need of assistance (asst.) with activities of daily living (ADL). SLP providers (prov.) must have apartments (apts.) with a lockable entry door, living area, bedroom, kitchen and a bathroom that affords privacy. Participants (partic.) only share double occupancy apartments by choice. Partic. may receive visitors of their choice at any time. Partic. come and go from their apt. and the building as they choose. Partic. may obtain employment, volunteer, shop and pursue any activities (activ.) they like in the community. Common areas in the building are accessible to all and allow for dining, socialization, computer access and partic. personal use.

The SLP prov. supplies partic. with individualized svcs., including: medication oversight, routine health assessments by licensed nurses, well-being checks, asst. with ADLs, laundry, housekeeping, social and health promotion activ. and arranging for necessary outside svcs.

Access to the community is promoted through activ. both onsite and outside of the SLP. Opportunities for community involvement are communicated to partic. in the form of calendars, newsletters, email and also verbally. Examples of activ. that provide an opportunity for community access outside of the SLP include: musical events, religious services, educational and charity opportunities, sporting events, shopping, museum trips and scenic drives. Partic. are encouraged to provide input re. activ. SLP prov. also encourages indiv. participation in the community, such as visiting friends, volunteering or taking classes. The required partic. assessment includes identifying a person's interests. Additionally, the community is invited to be a part of activ.. Examples include presentations by medical professionals, children, musical groups and faith based groups.

The purpose of the SLP is to promote the health and independence of partic. by offering the necessary supports and services. The SLP is an alternative to nursing facility care and also to living alone in the community where comprehensive support svcs. may not be available.

The Goals of the SLP include:

#### Health and Safety

Many partic. enter the SLP directly from their own home where they might not be receiving regular assist. with supports, such as medication oversight, meals, hygiene, well being checks and overall health monitoring. The SLP provides these svcs., which assist partic. with maintaining their health and independence.

#### Quality of Life

Partic. who previously resided in skilled nursing facilities are able to experience more freedom and are encouraged to be more independent in a SLP building. They are free to come and go, decorate their apt., participate in activities of their choosing, cook meals or eat in the dining room. Partic. also are involved with the develop. of an individualized service plan, which reflects the svcs. and care they need and prefer, along with any svcs. they refuse. Additionally, partic. who previously lived in their own homes may have been isolated and not had regular opportunities for interaction with others and their community. The SLP encourages socialization within the SLP and with the community at large.

#### Increased Service Options

The SLP provides partic. with another option for support svcs. that promote health and safety and encourage independence. The licensed Assisted Living Program in IL is not subsidized by public funds and therefore is not an affordable option for many people. Independent living and subsidized housing do not offer many of the supports waiver partic. need, such as medication oversight. Without the SLP, nursing facilities are the only other care option for many people of low income who require more services than they can obtain in their home.

#### Cost Savings

With a Medicaid reimbursement rate less than that of nursing facilities, the SLP decreases the State's cost of care for partic. who otherwise would be institutionalized. One main objective of the SLP is to decrease or divert individuals from nursing facilities who do not need skilled services.

The Dept. of Healthcare & Family Services is the State Medicaid agency (SMA) and is responsible for oversight of the SLP. Svcs. are accessed on the local level at individual SLP providers. Applications for Medicaid are also made at the state level at the Dept. of Human Services, Family and Community Resource Centers located throughout the state and online.

Partic. are encouraged to make their own decisions about the svcs. they receive. The svcs. provided are based on the partic.'s individual needs and preferences and are supplied in accordance with the person centered service plan.

### **3. Components of the Waiver Request**

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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

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- 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:*

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## 5. Assurances

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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

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*Note: Item 6-1 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 inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s)

of their choice; or (c) whose services are denied, suspended, reduced or terminated. Appendix F specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

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

**I. Public Input.** Describe how the State secures public input into the development of the waiver:

Public notice was issued on 1/26/17 via the SMA's website at:

<https://www.illinois.gov/hfs/SiteCollectionDocuments/PublicNoticeSLPwaiverrenewal.pdf>. Those interested in providing input were asked to send their feedback via email to [HFS.SLF@illinois.gov](mailto:HFS.SLF@illinois.gov) or via U.S. mail to the Department (Dept.) of Healthcare and Family Services, Bureau of Long Term Care, 201 S. Grand Ave., 3rd Floor, Springfield, IL 62763.

On 1/27/17, the SMA informed via U.S. mail and e-mail and sought feedback from our representative (rep.) of the Tribal Authority or First Nation of ILs' intent to renew this waiver. This date of notice was 60 days prior to ILs' original intent to submit the waiver renewal. In all letters to the Authority, the SMA offered to meet and discuss the waiver. Evidence of all letters is available through the SMA.

The SMA sent an e-mail to SLP providers which included a copy of the waiver renewal application (app.) informing them of the public notice and requesting this information be shared with participants.

COMMENT(C) #1: The commenter asks if the SMA believes CMS will approve the app.with the proposed rate methodology language.

RESPONSE (R): The SMA anticipates CMS may have additional questions.

C #2: The comment states the waiver app. does not meet CMS requirements for person-centered planning.

R: The SMA will add additional language to this section of the app. to better capture the person-centered aspects of the service plan.

C #3: The comment states the waiver app. does not meet CMS requirements for person-centered planning as it relates to Limited English Proficiency Access to Information.

R: The SMA will revise the waiver app. to state written materials provided to a participant(partic .)must be in a language understandable to him/her.

C #4: The comment expresses concerns with the SLP waiver's compliance with new federal community setting requirements. The commenter states there is a concern the SLP is not compliant with the person-centered model.

R: ILs' final Statewide Transition Plan has been submitted to CMS. The SMA will work with CMS to ensure compliance.

C #5: The comment expresses concerns with claiming of FFP as it relates to development of the partic.'s service plan.

R: The SMA can claim FFP on the date a partic. begins receiving services from a SLP provider because an initial service plan is created within 24 hours which identifies waiver services being provided.

C #6: The comment suggests removing "taking college classes" as a specific example to support a "home-like setting" in the SLP waiver.

R: The SMA will revise the waiver app. to include "additional learning opportunities".

C #7: The comment suggests deleting language regarding Registered Nurse (RN) coursework because individual coursework is not able to be verified by the SLP provider.

R: The IL Dept. of Financial and Professional Regulation (DFPR) licenses RNs. As part of licensure, DFPR reviews an individual's coursework prior to issuing a license. The SLP provider is responsible for ensuring the RN has current licensure in IL, but not for verifying coursework. The SMA will not remove this language from the app.

C #8: The comment offers concerns regarding compliance with HIPAA as it relates to Freedom of Information Act (FOIA) requests for SLP provider reviews.

R: The SMA is compliant with FOIA requests. Protected health information is redacted from FOIA responses as applicable. SMA legal staff review all requests from the participant's family and FOIA responses to verify compliance with HIPAA. A statement will be added to the app. referencing compliance with HIPAA as it relates to these requests.

C #9: The comment suggests removing the current requirement of ongoing reassessments for the necessity of delayed egress in SLP dementia care settings.

R: The SMA will not revise the current requirements for completion of the Elopement Risk Assessment in SLP dementia care settings. This is a CMS requirement.

C # 10: The comment raises concerns regarding the development of a new rate methodology.

R: The SMA will include SLP providers and stakeholders in the development of a new rate methodology. An amendment will be submitted to CMS when the new rate methodology is finalized. The amendment will also allow for a public comment period.

See B. Add'l Needed Info. for more.

Specific to Statewide Transition Plan:

IL established a LTSS Inter-Agency workgroup in April, 2014 to address the Statewide Transition Plan (STP) in response to the HCBS new regulations. This workgroup continued to meet throughout the implementation of the STP.

In accordance with CMS-2249-F/2296-F,(iii), IL provided a 32-day public notice and comment period with two statements of public notice, one non-electronic and one electronic with several methods to inform and engage the public in providing the State with feedback on the draft STP. In addition, IL informed and sought feedback from our rep. of the Tribal Authority or First Nation. The STP reflects input received and has been modified accordingly.

ILs' strategies to comply with public notice and input are detailed in the STP to comply with (CMS) 2249-F and 2296-F Regarding Home and Community-Based Services (HCBS) Settings Rules in ILs' 1915(c) Waivers, which was submitted to federal CMS on 3/16/15 and can be found at:  
<http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Transition/Pages/default.aspx> .

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

A revised STP was posted for public notice on 11/9/16 that included information regarding the on-site visits of some waiver providers.

The input that was received was incorporated into the STP or there was indication in the STP of either the inability of the State to respond or how the State intends to respond to comments in the future. The STP was submitted to CMS on 2/1/17.

- 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)

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

Last Name:

First Name:

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:**

**Zip:**

**Phone:**  Ext:   TTY

**Fax:**

**E-mail:**

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**

**City:**

**State:**

**Zip:**

**Phone:**  Ext:   TTY

**Fax:**

**E-mail:**

**8. Authorizing Signature**

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

**Signature:**

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Zip:

Phone:  Ext:   TTY

Fax:

E-mail:

**Attachments**

**Attachment #1: Transition Plan**

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

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

Specify the transition plan for the waiver:

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

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

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe*

attainment of milestones.

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

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

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

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

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

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

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

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

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

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

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

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

### **Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

A second public notice was issued on May 31, 2017 via the SMA's website at: <https://www.illinois.gov/hfs/SiteCollectionDocuments/6917HCBSWaiverPublicNoticeSLF.pdf>. A non-electronic public notice was available at local Department of Human Services offices and in Cook County at the SMA's Director's office. A hard copy of the waiver renewal was available for download and in hard copy at two HFS offices identified in the public notice. Public comments were accepted through June 30, 2017. Those interested in providing input were asked to send their feedback via email to [HFS.HCBSWaiver@illinois.gov](mailto:HFS.HCBSWaiver@illinois.gov) or via U.S. mail to the Department of Healthcare and Family Services, ATTN: Waiver Management, 201 S. Grand Ave., 2nd Floor, Springfield, IL 62763.

Comment #1:

The commenters provided background information regarding the programs they represent, the Fair Housing Act and court rulings.

Response:

No response is necessary as this is not applicable to the waiver renewal.

Comment #2:

The commenter described the plaintiff involved in a lawsuit with the SMA.

Response:

This comment is related to litigation and is not applicable to the waiver renewal.

Comment #3:

This comment raises allegations related to litigation that are in dispute regarding Appendix B-1 of the current approved waiver and administrative rules. The commenters state the Supportive Living Program (SLP) and Appendix B-1 of the current approved waiver excludes individuals with mental health conditions.

Response:

The comment is related to litigation issues regarding the current approved waiver application and administrative rules. Appendix B-1 of the waiver renewal states the SLP does not exclude specific diagnoses, as long as eligibility requirements are met and the person is appropriate for placement with the SLP provider. Additionally, Appendix B-1 of the waiver renewal says the State will use PASRR reviewers to assess for persistent risks and needs to inform whether the person is appropriate for placement with the SLP provider. There is no language within the renewal application that states persons should or may be excluded from an SLP provider based on diagnosis of mental illness without consideration of their actual eligibility for the program.

The 89 Illinois Administrative Code Section 146.220(a)(3) currently states SLP waiver participants must "Be without a primary or secondary diagnosis of a developmental disability or a serious and persistent mental illness. The developmental disability or mental illness must be determined by a qualified Department of Human Services screening agent". The SMA is developing proposed administrative rule changes for the 89 Illinois Administrative Code Section 146.220(a)(3). Public comment will be sought for this change. Proposed administrative rule changes will align with language in the waiver renewal approved by the Centers for Medicare and Medicaid Services.

Additionally, the SMA partnered with the Department of Human Services and the Department on Aging in 2017 to provide training for screening staff and providers regarding the screening process. The Departments of Healthcare and Family Services and Human Services worked to add language to the PASRR manual clarifying the appeal process for a potential SLP resident. Information regarding the appeal process will be added to the waiver renewal.

**Comment #4:**

The commenter described the plaintiff involved in a lawsuit with the SMA.

**Response:**

This comment is related to litigation and is not applicable to the waiver renewal.

**Comment #5:**

The commenter described an investigation completed by the plaintiff of a lawsuit.

**Response:**

This comment is related to litigation and is not applicable to the waiver renewal.

**Comment #6:**

The commenter described litigation.

**Response:**

This comment is related to litigation and is not applicable to the waiver renewal.

**Comment #7:**

This comment is related to litigation and the current approved waiver. The commenter would like the elimination of all language in the current approved waiver stating that persons should or may be excluded from the SLP based a diagnosis of mental illness.

**Response:**

Most of the comment relates to litigation and the current approved waiver. Appendix B-1 of the waiver renewal states the SLP does not exclude specific diagnoses, as long as eligibility requirements are met and the person is appropriate for placement with the SLP provider. Additionally, Appendix B-1 of the waiver renewal says the State will use PASRR reviewers to assess for persistent risks and needs to inform whether the person is appropriate for placement with the SLP provider. There is no language within the renewal application that states persons should or may be excluded from an SLP provider based on diagnosis of mental illness without consideration of their actual eligibility for the program.

**Comment #8:**

The commenter described litigation.

**Response:**

This comment is related to litigation and is not applicable to the waiver renewal.

**Comment #9:**

The commenter describes litigation and quotes language in Appendix B-1 of the current approved waiver and in the proposed waiver renewal.

**Response:**

This comment is related to litigation and quotes language in the current approved waiver and the proposed waiver renewal. There is no response applicable to the waiver renewal.

**Comment #10:**

The commenters state the waiver does not respond to issues relating to disputes alleged in litigation: the systemic manner in which the SLP violates the law in regards to persons with mental illness, the proposed waiver changes do not address the effects of past discrimination against persons with mental health diagnoses or conditions, the scope of the waiver renewal is seriously flawed, and the revisions to the renewal waiver are likely to have limited practical effect. The commenters state it "...cannot be remediated with the text of the proposed waiver itself...".

**Response:**

It has not been determined that the current approved SLP waiver or the waiver renewal violates any laws. The waiver renewal does not include any language that would prohibit a person with a mental illness from participating in the waiver.

**Comment #11:****Summary of comment:**

The commenter describes various points related to litigation, including: the current approved waiver, administrative rules for the SLP, various program documents and screening processes, PASRR and appeal processes that all discriminate against persons with mental illness.

**Response:**

The comment raises many disputed litigation issues that are not applicable to the waiver renewal. Appendix B-1 of the waiver renewal states the SLP does not exclude specific diagnoses, as long as eligibility requirements are met and the person is appropriate for placement with the SLP provider. Additionally, Appendix B-1 of the waiver renewal says the State will use PASRR reviewers to assess for persistent risks and needs to inform whether the person is appropriate for placement with the SLP provider. There is no language within the renewal application that states persons should or may be excluded from an SLP provider based on diagnosis of mental illness without consideration of their actual eligibility for the program

The 89 Illinois Administrative Code Section 146.220(a)(3) currently states SLP waiver participants must “Be without a primary or secondary diagnosis of a developmental disability or a serious and persistent mental illness. The developmental disability or mental illness must be determined by a qualified Department of Human Services screening agent”. The SMA is developing proposed administrative rule changes for the 89 Illinois Administrative Code Section 146.220(a)(3). Public comment will be sought for this change. Proposed administrative rule changes will align with language in the waiver renewal approved by the Centers for Medicare and Medicaid Services.

Additionally, the SMA partnered with the Department of Human Services and the Department on Aging in 2017 to provide training for screening staff and providers regarding the screening process. The Departments of Healthcare and Family Services and Human Services worked to add language to the PASRR manual clarifying the appeal process for a potential SLP resident. Information regarding the appeal process will be added to the waiver renewal.

**Comment #12:**

The commenter describes many points related to litigation and requests the State develop and implement a process for identifying individuals that have been “rejected or deterred from applying” on the basis of mental health requirements and offer additional application, screening and re-consideration.

**Response:**

This comment raises many disputed litigation issues that are not applicable to the waiver renewal. Appendix B-1 of the waiver renewal states the SLP does not exclude specific diagnoses, as long as eligibility requirements are met and the person is appropriate for placement with the SLP provider. Additionally, it says the State will use PASRR reviewers to assess for persistent risks and needs to inform whether the person is appropriate for placement with the SLP provider. There is no language within the renewal application that states persons should or may be excluded from an SLP provider based on diagnosis of mental illness without consideration of their actual eligibility for the program

The Departments of Healthcare and Family Services and Human Services worked to add language to the PASRR manual clarifying the appeal process for a potential SLP resident. Information regarding the appeal process will be added to the waiver renewal.

**Comment #13:**

The commenters describe points related to litigation and state the renewal application does not contain an unequivocal statement prohibiting discrimination on the basis of mental health conditions or affirming compliance with the Fair Housing Act, the Americans with Disabilities Act or the Rehabilitation Act. The commenters disagree with using PASRR to determine participant eligibility. The commenter requests the state provide benchmarks that will assure persons with mental health conditions will be properly screened for eligibility and due process in cases where housing is denied.

**Response:**

This comment raises many disputed litigation issues that are not applicable to the waiver renewal. Appendix B-1 of the waiver renewal states the SLP does not exclude specific diagnoses, as long as eligibility requirements are met and the person is appropriate for placement with the SLP provider. Additionally, Appendix B-1 of the waiver renewal says the State will use PASRR reviewers to assess for persistent risks and needs to inform whether the person is appropriate for placement with the SLP provider. There is no language within the renewal application that states persons should or may be excluded from an SLP provider based on diagnosis of mental illness without consideration of their actual eligibility for the program

The renewal application does not require a specific statement regarding compliance with the Fair Housing Act, the Americans with Disabilities Act or the Rehabilitation Act. Persons whose initial level of care screening does not determine

them to be eligible for waiver services are not allowed access to SLP waiver services. The Departments of Healthcare and Family Services and Human Services have worked together to add additional language to the PASRR manual clarifying the appeal process for a decision on a clinical review of serious and persistent mental illness and clinical and/or behavioral needs of a potential SLP resident. Information regarding the appeal process will be added to the waiver renewal.

**Comment #14:**

The commenters offer fifteen separate points, most of which relate to the litigation.

**Point A.**

Appendix A Forms previously and currently used perpetuate discrimination and do not allow for adequate documentation of screening, due process notification, or centrally maintained screening results for applicants with mental health issues. Training of CCU's and their staff is also not addressed.

**Response:**

Appendix A-5, Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities, states in part, "The SMA reviews the screening results forms completed by local Case Coordination Units for all new Supportive Living Program participants annually". This statement refers the HFS 2536 Results of Interagency Screening Results form used to document the level of care screening completed to determine eligibility for the waiver, not any other assessment. This comment is not applicable to Appendix A-5 of the waiver renewal.

**Point B**

Appendix A-7.b.i. fails to address significant evidence that tracking problems is inadequate in light of documentation failures as well as the identified problems and insufficiencies in the DHS UHS data base relating to PASRR, SLP applicants and SLFs, as well as relating to mental health level of care and recommendations.

**Response:**

Appendix A Quality Improvement b.i

The language in Appendix A-7.b.i describes how the SMA monitors remediation related to the completion of level of care screening forms. It is not applicable to PASRR.

**Point C**

Appendix B-3.f fails to identify or set forth criteria or basis for reporting and documenting analysis of whether applicant needs nursing facility level of care or is "appropriate for placement" in cases where there is a PASRR screen

**Response:**

The language in Appendix B-3.f. is a broad overview. Specific processes for eligibility determination and participant requirements are included in other sections of Appendix B and are not required in Appendix B-3.f.

**Point D**

Appendix B-6 regarding evaluation/reevaluation of level of care states that the SLF may gather additional information from physicians and other healthcare providers but fails to specify, when, by whom, and how this must be done and fails to address how non-discrimination based on mental health issues will be ensured.

**Response:**

The language in Appendix B-6.f. is applicable to the level of care determination, in this case a minimum score of 29 on the Determination of Need Assessment completed by CCU or DRS staff or a minimum score on the annual Level of Care Determination completed by SMA staff. This section of the waiver renewal does not state SLP provider staff request additional information. It states SMA staff may request additional information for an annual Level of Care Determination. The SMA will add a sentence to clarify that CCU staff or DHS DRS staff may request additional information.

**Point E**

Appendix B-6.c. fails to specify that SLF staff are not qualified or authorized to do screening but have been permitted to effectively do it in whole or part, fails to address SLFs improperly obtaining medical or psychiatric information at all or at incorrect phases of the process, and should set forth a specific order of events regarding screening and tasks limited to State agencies.

**Response:**

<https://wms-mmdl.cms.gov/WMS/faces/protected/35/print/PrintSelector.isp>

Appendix B-6.c. of the waiver renewal is specific to initial level of care evaluations for the waiver completed by CCU or DHS DRS staff, not SLP provider staff. Appendix B-6-c clearly identifies who completes initial level of care evaluations and their qualifications. SLP provider staff is not identified.

**Point F**

Appendix B-6.d. fails to specify how, when and by whom mental health issues will be addressed and properly considered.

**Response:**

Appendix B-6.d. of the waiver renewal is specific to initial level of care evaluations for the waiver completed by CCU or DHS DRS staff, not other assessments. The initial level of care evaluation determines eligibility for waiver services. It is not used as an assessment to identify specialized needs or services.

**Point G**

Appendix B-6.d. fails to address non-discrimination regarding "meet needs" assessments and applicants with mental health issues.

**Response:**

Appendix B-6.d. of the waiver renewal is specific to initial level of care evaluations for the waiver completed by CCU or DHS DRS staff, not other assessments.

**Point H**

Appendix B-6.h. fails to address established practices of (a) contractors requiring SLFs to preemptively obtain medical records and lists of medications and (b) unqualified SLF staff being permitted to preemptively screen applicants based on improper criteria.

**Response:**

Appendix B-6.h. of the waiver renewal is specific to annual level of care evaluations for the waiver completed by SMA staff, not other assessments.

**Point I**

Appendix D-1.c. (3 of 8) fails to require a non-discrimination provision in the required "contract/lease agreement," and fails to specify that compliance with the Fair Housing Act, ADA and Rehabilitation Act is required of SLFs.

**Response:**

Appendix D-1.c. of the waiver renewal requests the SMA to provide information regarding 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 the participant's authority to determine who is included in the process.

The IL Administrative Code 146.240(b)(4) states, "The resident contract shall include, but not be limited to the following: The SLF's agreement to comply with all applicable federal, State and local laws and regulations. The SMA will add this administrative code language to the renewal application.

**Point J**

Appendix D-1.d. (4 of 8) fails to specify how and when and by whom information regarding mental health and medications will be obtained and fails to include a non-discrimination statement regarding past exclusions in the SLP based on mental health diagnosis.

**Response:**

This section of the waiver requests information regarding how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs) and preferences. The comment is not relevant to the information required.

**Point K**

"Standardized Interview" referenced in Appendix D-1 should be reviewed regarding non-discrimination based on diagnosis of mental health issues,

**Response:**

The 89 Illinois Administrative Code Section 146.245(a) requires a SLP provider to complete a standardized interview geared towards the participant's service needs before or at the time of admission. The SMA will review this rule language and determine if any administrative rule changes are necessary. Any proposed administrative rule change would include a public comment period.

**Point L**

Appendix D-1 concerning how the participant is informed of services of the Waiver should specify an appropriate order of process as well as ensure non-discrimination based on mental health diagnosis (See HOPE Fair Housing Consent Decrees with Eden Supportive Living and Eastgate Manor).

**Response:**

Appendix D-1-c requests information related to service plan development. The language in the renewal application states that the resident contract has to include information regarding the waiver services that are available to participants. This is included to verify that participants are made aware of the waiver services they may receive in order to assist them with the development of their individualized service plan. This is not applicable to any screening or assessment process.

**Point M**

Appendix D-2 should require and specify monitoring for non-discrimination based on mental health diagnosis and related issues. Monitoring samples should include evaluation of how the needs of applicants and residents with mental health issues are assessed and met.

**Response:**

Appendix D-2-a describes how the SMA monitors the implementation of participants' service plans. This is not applicable to any level of care eligibility screening or assessment process. As with any diagnosis, if a participant required services related to mental health condition, SMA staff would verify this was being provided to the participant and was included in their service plan. There is not a separate process specific for persons with a mental health condition.

**Point N**

Appendix F-1 fails to address or rectify that for applicants undergoing PASRR screenings (under unspecified processes and policies), there is no due process offered and the forms used and documentation maintained are inapposite and inadequate.

**Response:**

The Departments of Healthcare and Family Services and Human Services worked to add language to the PASRR manual clarifying the appeal process for a potential SLP resident. Information regarding the appeal process will be added to the waiver renewal.

**Point O**

Appendix H-1, concerning Quality Improvement Strategy ("QIS") fails to mention or address the change in exclusion based on diagnosis of mental illness, fails to specify how QIS has or will address discriminatory exclusion based on mental illness, and fails to direct that QIS might address administrative rule changes, policy and procedures changes, training needs and changes in standardized forms that require modification according to the evidence in the pending SLP discrimination litigation matters.

**Response:**

This comment is not applicable to Appendix-H-1 of the waiver renewal. Appendix H-1 of the waiver renewal requires the description of the Quality Improvement Strategy for the SLP, including processes for trending, prioritizing, and implementing system improvements prompted as a result of an analysis of discovery and remediation information. Appendix H-1 of the waiver renewal is meant to capture information regarding overall continuous quality improvement processes for the SLP, not specific issues identified during the analysis of discovery and remediation.

**Comment #15:**

The commenter believes that proposed waiver revisions would only have a limited effect.

**Response:**

The SMA's SLP waiver renewal includes all of the necessary requirements of a 1915(c) Home and Community Based Services waiver.

**WAIVER AMENDMENT FOR MANAGED CARE EXPANSION:**

Public notice was issued on March 1, 2018 via the SMA's website at: <https://www.illinois.gov/hfs/info/legal/PublicNotices/Pages/default.aspx>. Those interested in providing input were asked to send their feedback via email to [HFS.HCBSWaiver@illinois.gov](mailto:HFS.HCBSWaiver@illinois.gov) or via U.S. mail to the Department of Healthcare and Family Services, ATTN: Waiver Management, 201 S. Grand Ave., 2nd Floor, Springfield, IL 62763. A non-electronic public notice was available at local Department of Human Services offices and in Cook County at the SMA's Director's office. A hard copy of the waiver renewal was available for download and in hard copy at two HFS offices identified in the public notice. Public comments were accepted through March 30, 2018.

On March 1, 2018, the SMA informed via U.S. mail and e-mail and sought feedback from our representative (rep.) of the Tribal Authority or First Nation of ILs' intent to renew this waiver. In all letters to the Authority, the SMA offered to meet and discuss the waiver. Evidence of all letters is available through the SMA.

The SMA sent an e-mail to SLP providers which included a copy of the waiver renewal application (app.) informing them of the public notice and requesting this information be shared with participants.

**Appendix A: Waiver Administration and Operation**

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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:  
**Division of Medical Programs**  
*(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:

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**

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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:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

## 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.*

Local Case Coordination Units perform initial level of care evaluations.

Illinois' mandatory managed care program, now called HealthChoice Illinois, will operate statewide effective April 1, 2018 offering providers the opportunity to contract with five managed care plans in all Illinois counties; seven managed care plans will be available in Cook County. The Integrated Care Program (ICP), Family Health Plan/ACA Adults (FHP/ACA) and Managed Long Term Services and Supports (MLTSS) managed care programs are not incorporated in HealthChoice Illinois. Members enrolled in the Medicare Medicaid Alignment Initiative (MMAI) are not impacted by HealthChoice Illinois. For those waiver participants enrolled in a Managed Care Organization (MCO), the Plans will be responsible for care coordination, service plan oversight, participant safeguards, prior authorization of waiver services, and quality assurance and quality improvement activities.

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

## Appendix A: Waiver Administration and Operation

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

- Not applicable**
- Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.**

Check each that applies:

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

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

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

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

## **Appendix A: Waiver Administration and Operation**

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

The SMA reviews the screening results forms completed by local Case Coordination Units for all new Supportive Living Program waiver participants annually.

In the SMA's contracts with MCOs that provide waiver services, the SMA 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 measures, the sources are MCO reports and External Quality Review Organization (EQRO) medical record reviews.

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

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

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

## **Appendix A: Waiver Administration and Operation**

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- 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 Medicaid agency (SMA) reviews the screening results forms of all new waiver participants annually. These

forms are completed by Case Coordination Units. SMA staff audit the forms to verify they are complete and accurate.

**Oversight of MCOs:**

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

Once the SMA selects the sample, it is provided to the 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 sends a report of findings to the SMA and the MCOs. The MCOs are required to remediate findings within required timelines. The MCOs report remediation activities to the SMA at least quarterly.

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

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

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

**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	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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:**

**#/% of new waiver participants' screening results forms submitted by CCU or DHS Division of Rehabilitation Services (DRS) as part of the level of care process that were complete and accurate. Num: Number of new waiver participants with screening results forms submitted by CCU or DRS that were complete and accurate. Den: Total number of screening results forms for new waiver participants.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

#/% of new dementia prog. waiver partic. screening results forms submitted by CCU or DHS Div. of Rehab. Services (DRS) as part of the level of care determination process that were complete and accurate. Num: # of new dem. prog. waiver partic. with screening results forms submitted by CCU or DRS that were complete and accurate. Den: Total # of screening results forms for new dem. program partic.

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

#/% of SLP providers utilized by the MCOs that are enrolled Medicaid providers.

Numerator: Number of SLP providers utilized by the MCOs that continued to maintain certification. Denominator: Total number of enrolled certified SLP providers utilized by the MCOs.

**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):
<input type="text"/>	<input type="text"/>	<input type="text"/>

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/> ^ <input type="text"/> v
<input checked="" type="checkbox"/> Other Specify: MCO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/> ^ <input type="text"/> v
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/> ^ <input type="text"/> v
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/> ^ <input type="text"/> v	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/> ^ <input type="text"/> v

**Performance Measure:**

#/% of participant reviews conducted by the EQRO according to sampling methodology specified by the waiver. Numerator: Number of participant reviews conducted by the EQRO according to the sampling methodology specified in the waiver. Denominator: Total number of participant reviews by the EQRO required according to the sampling methodology.

Data Source (Select one):  
Other

If 'Other' is selected, specify:

**EQRO Reports**

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

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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 SMA will conduct routine programmatic and fiscal monitoring for the MCOs.

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

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

**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.

PM 1 & 2:

If a new waiver participant's screening results form is found to be incomplete or inaccurate, the SMA provides a copy of the form to the Department on Aging (DoA) for local Case Coordination Units (CCU) or the Department of Human Services (DHS) for the Division of Rehabilitation Services (DRS). DoA or DHS notifies the appropriate screening staff to bring errors to their attention so the non-compliance can be reviewed and any necessary remediation be completed. If the non-compliance results in a non-payable service period for the waiver participant or a determination that the participant was ineligible for waiver services, the SMA would recover payment. If persistent problems with specific CCU or DHS employees were identified, the SMA would seek a meeting with the respective state agency to discuss continuous quality improvement activities, such as staff training or personnel action.

PM 3:

Upon discovery of an MCO utilizing a provider that is not an enrolled Medicaid provider, the MCO is notified to transfer participants. SMA staff would assist with identifying other providers, including SLP providers. Remediation shall occur immediately. The MCO would need to implement a plan of correction. Payment recovery by the SMA could occur.

PM 4:

The EQRO completes case reviews and reviews the scheduling/process to determine reasons for reviews not being conducted. If remediation is not within 90 days, the EQRO reviews procedures and submits a plan of correction to the SMA. The SMA agency would follow-up to verify completion .

- 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**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
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	22	64	
	<input type="checkbox"/>	Disabled (Other)			
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

Potential Supportive Living Program (SLP) waiver participants must also be screened and meet nursing facility level of care. The SLP does not exclude specific diagnoses, as long as the eligibility requirements are met and the person is appropriate for placement with the SLP provider. The State will use PASRR reviewers to assess for persistent risks and needs to inform whether the person is appropriate for placement with the SLP provider.

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:

Supportive Living Program providers serving persons with physical disabilities do not have a maximum age limit after resident is admitted. Although the participant cannot be older than age 64 at the time of admission, participants are able to remain at the SLP provider after that age.

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

- The following dollar amount:

Specify dollar amount:

The dollar amount (*select one*)

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

Specify the formula:

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

Specify percent:

- Other:

Specify:

### Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

- 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:

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

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

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

- 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	12132
Year 2	12465
Year 3	12666
Year 4	12965
Year 5	13167

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

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

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

Table: B-3-b

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

**Appendix B: Participant Access and Eligibility**

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

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

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

**Appendix B: Participant Access and Eligibility**

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

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

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

e. **Allocation of Waiver Capacity.**

Select one:

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

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

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

The waiver provides for the entrance of all eligible persons.

Participants in the Supportive Living Program (SLP) waiver must be age 65 years or older, or ages 22-64 and have a physical disability, as determined by the Social Security Administration. The SLP also offers a dementia program at specially certified providers. Any person who meets all other program requirements and displays/exhibits symptoms related to internal pathological changes in the brain that affect intellectual and social abilities severely enough to interfere with daily functioning which makes it unsafe for them to reside by themselves may be assessed for the SLP dementia program. Just like other SLP participants, dementia program participants do not require 24-hour skilled nursing care.

Potential participants must also be screened by the State Medicaid agency (SMA) or its designee and found to be in need of nursing facility level of care and appropriate for placement with a SLP provider.

All potential participants must be checked against two state and one national sex offender registration websites and have a tuberculin skin test in accordance with the Illinois Control of Tuberculosis Code.

Individuals participating in the SLP waiver cannot receive services from any other Home and Community Based Services waiver.

Potential participants must apply and be approved for Medicaid.

Finally, individuals must have the resources to pay for the cost of room and board and to receive a personal allowance, both of which are established by the SMA.

For participants enrolled in MCOs, State-established policies governing the selection of individuals for entrance to the waiver will remain the same as for all participants. Initial waiver eligibility will be conducted by the same entities as designated for those not enrolled in managed care and will be based on the same objective criteria. 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:*

Public Law 111-148 Patient Protection and Affordable Care Act:

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 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. 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 waiver participants equals the maximum income an individual can have and be eligible under 42 CFR 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**
- The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**  
*Specify:*

**Specify the amount of the allowance (select one):**

- 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).

##### i. Allowance for the personal needs of the waiver participant

(select one):

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

Specify percentage:

- The following dollar amount:

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

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

Specify formula:

- Other

Specify:

The maintenance allowance for the waiver participants equals the maximum income an individual can have and be eligible under 42 CFR 435.217 group.

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

Select one:

- Allowance is the same
- Allowance is different.

*Explanation of difference:*

- iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:
- a. Health insurance premiums, deductibles and co-insurance charges
  - b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

Answers provided in Appendix B-5-a indicate the selections in B-5-c also apply to B-5-f.

## 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 the selections in B-5-d also apply to B-5-g.

**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:

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

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

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

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

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

*Specify the entity:*

- Other**
    - Specify:*

The SMA has agreements with the Department on Aging and the Department of Human Services, Division of Rehabilitation Services to perform initial level of care determinations for potential waiver participants. The SMA conducts reevaluations annually.

- 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:

As stated in 89 Ill Adm Code, Chap. II, Section 220.605, contractors of the Department on Aging who perform initial level of care evaluations for potential waiver participants must be:

1. A registered nurse, or have a Bachelor of Science in Nursing, or have a Bachelor degree in social science, social work or related field. One year of program experience which is defined as assessment, provision, and/or authorization of formal services for the elderly, may replace one year of college education up to and including four years of experience replacing a Baccalaureate Degree, OR
2. Be a licensed practical nurse with one year of program experience which is defined as assessment of and provision of formal services for the elderly and/or authorizing service provision.

The Department of Human Services, Division of Rehabilitation Services requires a Master's degree from a college or university program accredited by the Council on Rehabilitation Education (CORE); or a Master's degree from an accredited college or university in rehabilitation counseling, rehabilitation administration, clinical psychology, counseling psychology, deaf education, special education, social work, sociology, gerontology and nursing or a closely related field.

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

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

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

The DON is composed of three parts: demographic, cognitive status and functional status. The Mini-Mental Status Examination (MMSE) Section includes eleven items. The first two items are used to measure a person's orientation. The third question tests the ability of the applicant to register, i.e. learn and remember new information. The fourth item measures the person's ability to attend to a task and perform a mental function. The fifth item measures the person's short term recall. Remaining items in this section test a person's basic ability to use and understand words.

The functional status section assesses the level of assistance a person requires with activities of daily living, including: eating, bathing, grooming, dressing, transferring, continence, managing money, telephoning, preparing meals, laundry, housework, outside of home, routine health, special health and being alone.

Reevaluations are performed annually by the SMA through examination of the participant's comprehensive assessment. The comprehensive assessment is completed by the SLP provider's registered nurse near the time of the waiver participant's admission and annually thereafter. It must also be updated as needed to reflect any significant changes in condition. The annual Level of Care Determination (LOCD) tool captures scores from specific sections of the comprehensive assessment, including: cognition, decision making, transferring, dressing, eating, toileting, personal hygiene, bathing, medication management, managing money, preparing meals/snacks, housekeeping and laundry. Assessments of these areas reflect services provided in the SLP waiver and used during initial level of care evaluation, which makes them relevant for reevaluation.

The initial and annual level of care criteria for participants enrolled in managed care is the same.

- 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:

As described in Section B 6 d, the Determination of Need (DON) is the standardized assessment tool used to perform initial level of care evaluations. Assessors complete the DON by asking questions of the potential waiver participant and/or his/her designated representative. Case Coordination Unit staff and Department of Human Services, Division of Rehabilitation Services staff completing the DON may request additional information from physicians and other healthcare providers.

Annual reevaluations for waiver participants are performed by the SMA. As described in Section B 6 d, sections of the comprehensive assessment are reviewed for each waiver participant. A Level of Care Determination form is completed to verify the waiver participant continues to require the services provided by the Supportive Living Program waiver. SMA staff may also interview the participant, his/her designated representative, other health care providers and SLP provider staff to obtain more information or clarification.

Waiver participants who do not meet level of care requirements based on the initial or the annual level of care evaluation are provided the opportunity to appeal the decision by the SMA.

For participants enrolled in an MCO, the annual reevaluation process is the same.

- 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:*

State Medicaid agency staff performs reevaluations. Most are Health Facilities Surveillance Nurses whose qualifications are:

--Current licensure as a registered nurse in the State of Illinois.

--Graduation from an approved nursing education program resulting in an associate or a diploma degree in nursing and three years of professional nursing experience, OR

--Bachelor's degree in nursing and two years of professional nursing experience, OR

--Master's degree in nursing

Staff may also be a Medical Assistance Consultant II whose qualifications are:

-Knowledge, skill and mental development equivalent to completion of four years of college with courses in medical social work.

--Two years professional experience in fields related to medical social work.

- 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*):

SMA procedures require annual onsite certification reviews be completed for all Supportive Living Program (SLP) providers. Policy requires that an annual Level of Care Determination (LOCD) be completed for each waiver participant during these reviews. SMA supervisory staff track due dates for annual reviews to ensure they are conducted within 60 days of the SLP provider's certification date.

Before the annual onsite certification review, a list of current waiver participants residing with the SLP provider is compiled from the long term care database, which is part of MMIS. This list identifies who requires an annual level

of care review. An automated LOCD tool is created that includes forms for each participant on the list from the long term care database. SMA staff completes the LOCD tool. The automated LOCD tool is reviewed after the annual onsite certification review to verify LOCDs were completed for each waiver participant or justification was included, such as a death.

- 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 records of initial level of care evaluations are kept by the Case Coordination Units and the Department of Human Services, Division of Rehabilitation Services for a minimum of three years. Records of reevaluations completed by the State Medicaid agency are kept for a minimum of three years. For participants enrolled in a MCO, the Health Plans will also maintain a copy of the forms. The record retention requirements will be the same for the Health Plans as required by CMS. The minimum is 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:

Number/percent of new waiver applicants who have a required initial level of care assessment prior to admission. Numerator: Number of new waiver applicants who have a required initial level of care assessment prior to admission. Denominator: Total number of new waiver applicants requiring initial level of care evaluations.

#### Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100%

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<b>Review</b> <input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number/percent of new dementia program waiver applicants who have a required initial level of care assessment prior to admission. Numerator: Number of new dementia program waiver applicants who have a required initial level of care assessment prior to admission. Denominator: Total number of new dementia program waiver applicants requiring initial level of care evaluation.

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

<input type="text"/>
----------------------

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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:**

**Number/percent of enrolled waiver participants evaluated annually as specified in the approved waiver. Numerator: Number of enrolled waiver participants evaluated annually as specified in the approved waiver. Denominator: Total number of enrolled waiver participants who required annual evaluation.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Level of Care Determination form**

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

**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):
<input type="checkbox"/>	<input type="checkbox"/>

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
<input checked="" type="checkbox"/> Continuously and Ongoing	
<input type="checkbox"/> Other Specify: <input type="text"/>	

**Performance Measure:**

Number/percent of enrolled dementia program waiver participants evaluated annually as specified in the approved waiver. Numerator: Number of enrolled dementia program waiver participants evaluated annually as specified in the approved waiver. Denominator: Total number of enrolled dementia program waiver participants who required annual reevaluation.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Level of Care Determination form**

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

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**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- 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:**

Number/percent of new waiver participants' annual level of care (LOC) determinations completed accurately. Numerator: Number of new waiver participants' annual LOCD determinations completed accurately. Denominator: Total number of new waiver participants requiring annual LOC determinations.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Level of Care Determination form

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100%

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number/percent of new dementia program waiver participants' annual Level of Care (LOC)determinations completed accurately. Numerator: Number of new dementia program waiver participants' annual LOC determinations completed accurately. Denominator: Total number of new dementia program waiver participants' LOC determinations reviewed.

**Data Source (Select one):**

Other

If 'Other' is selected, specify:

Level of Care Determination form

Responsible Party for	Frequency of data	Sampling Approach

data collection/generation (check each that applies):	collection/generation (check each that applies):	(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number/percent of waiver participant annual LOC determinations completed by qualified Department staff. Numerator: Number of waiver participants with

annual LOC determinations completed by qualified Department staff.  
 Denominator: Total number of waiver participant LOC determinations completed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Level of Care Determination form

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

	Specify: <input type="text"/>
--	----------------------------------

**Performance Measure:**

**Number/percent of dementia program waiver participant annual level of care (LOC) determinations completed by qualified Department staff. Numerator: Number of dementia program waiver participants with annual LOC determinations completed by qualified Department staff. Denominator: Total number of dementia program waiver participant annual LOC determinations completed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Level of Care Determination form**

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

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

**Remediation for Initial Level of Care (LOC) Assessments:**

When it is discovered that an initial LOC assessment has not been completed for a waiver participant, the LOC assessment is completed. If a participant is found ineligible, he/she is notified in writing by the SMA and provided appeal rights. Supportive Living Program (SLP) provider staff would assist the person with relocation assistance to another program or setting of the individual's choice.

Regardless of eligibility for waiver services, the SMA recovers all reimbursements paid for identified non-payable service periods as the result of initial LOC evaluation not being completed prior to admission to the waiver program. SMA staff change the date of eligibility for waiver services in MMIS to correspond with the first day of the allowable service period. Any claims prior to the allowable service period are voided. For service periods that begin after the first day of the month, the SLP provider would then submit a new claim for the allowable days for that month.

Additionally, the SLP provider may have to develop and implement a plan of correction. The SMA performs a follow-up review to determine compliance with initial LOC assessment requirements. Ongoing non-compliance results in sanction, including but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

**Remediation for Annual Level of Care Assessments:**

When it is discovered that an annual LOC has not been completed for a waiver participant, the LOC assessment is completed. If a person is found to be ineligible for waiver services during an annual LOCD assessment, he/she is notified in writing by the SMA and provided appeal rights. SLP provider staff would assist the person with relocation assistance to another program or setting of the individual's choice.

**Remediation for Annual Level of Care (LOC) Assessments that do not support Initial LOC Assessments:**

When it is discovered that an annual LOC assessment does not support the Initial LOC and the person is found ineligible for waiver services, he/she is notified in writing by the SMA and provided appeal rights. Supportive Living Program (SLP) provider staff would assist the person with relocation assistance to another program or setting of the individual's choice.

ii. Remediation Data Aggregation

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

<input type="text"/>	Frequency of data aggregation and analysis
----------------------	--

<b>Responsible Party</b> <i>(check each that applies):</i>	<i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**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).

At the time of the initial level of care evaluation, all potential waiver participants (or their designated representatives) are informed of feasible service options for either institutional care or waiver services. The Illinois Department on Aging Choices for Care Assessment form is used for this purpose. Section C., Service Selection and Applicant/Client Certification states, "I have been advised that I may choose community-based services, supportive living facility services or nursing facility placement. I understand that I have the right to change my mind at any time.". Services listed are: The Department on Aging's Community Care Program waiver, Department of Human Services waiver for persons with physical disabilities, the Supportive Living Program waiver or nursing facility placement. The participant indicates their service option choice with a check mark and signs his/her name. The Department on Aging's local Case Coordination Units, Department of Human Services, Division of Rehabilitation Services Rehabilitation Counselors are responsible for the completion of this form.

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

Copies of the Illinois Department on Aging Choices for Care Assessment Form are kept by local Case Coordination

Units and Department of Human Services, Division of Rehabilitation Services. The Medicaid agency maintains copies of forms for private pay residents converting to the waiver. For participants enrolled in a MCO, the Plans will maintain the Freedom of Choice 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):

Providers of the Supportive Living Program waiver serving Limited English Proficient (LEP) persons are required to take steps to ensure equal access to services for participants. Acceptable practices include: hiring bi-lingual staff, hiring persons or contracting with interpreters, engaging community volunteers or using available technology, such as language translator applications. Written materials provided to residents or their designated representatives must be in a language and format they can understand. For participants enrolled in a 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 State Medicaid agency. Where there is a prevalent single-language minority within the low income households (5% or more) where a language other than English is spoken, the Plan's written materials must be available in that language as well as 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		
Other Service	Assisted Living		

**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:

Assisted Living

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 care and supportive services that are furnished to waiver participants who reside in a homelike, non-institutional setting that includes 24-hour onsite response capability to meet scheduled or unpredictable participant needs and to provide supervision, safety and security. Services also include social and recreational programming and medication assistance. Additionally, medication administration, intermittent nursing services and periodic nursing evaluations are provided. Transportation for activities must be supplied, as well as arrangement for transportation to scheduled medical appointments. Additionally, Personal Emergency Response Systems (PERS) are required in participant apartments and common areas of the building. The system is connected to a Supportive Living Program (SLP) provider's emergency call system monitored by nursing and response personnel. Other services include: well-being checks, laundry, housekeeping, three meals per day, snacks, maintenance, assistance with shopping and assistance with access to the larger community. Services that are provided by third parties must be coordinated with the SLP provider.

Case management services are provided to assist participants in gaining access to needed waiver and other State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not made for 24 hour skilled care. Nursing services required in the Supportive Living Program (SLP) include: assessments, service plan development/approval and implementation, health promotion or disease prevention counseling and teaching self-care, medication set-up and medication administration. The use of home health services are also allowed in the SLP, as ordered by a physician, but is not a required service. SLP provider staff are expected to coordinate care and services with home health care providers. This includes, among other skilled services, wound care and physical and occupational therapy. SLP providers must assist participants with obtaining such services.

Access to the larger community is encouraged and is achieved through scheduled activities and assistance with individual preferences with regard to community involvement. Activities in the larger community may include volunteer/charity opportunities, musical presentations, religious program, sporting events, shopping, cultural destinations and outdoor activities like walking groups and fishing. Additionally, community members are involved with SLP participants by attending/providing onsite events. Medical professionals provide information on health and wellness, children's groups offer music and social interaction and faith-based groups supply spiritual programs. Opportunities for community involvement are communicated to participants both in writing through activity calendars and newsletters, as well as verbally. Additionally, as part of the participant's assessment, their interests and hobbies are identified to help SLP provider staff assist with community involvement.

All assisted living services are provided by employees of the SLP provider. Staff provides individualized participant services based on the comprehensive assessment and a participant's preferences as determined through the service planning process. All participants are entitled to receive all of the services provided by the SLP. Participants and others of their choosing, such as a family member, are involved with the development of the service plan. Participants are able to identify which services they would like to receive and the frequency of services. The SMA monitors SLP providers to ensure that individualization occurs and verifies that participant care needs are being met. This monitoring occurs during annual onsite certification reviews and complaint investigations.

Payment for the SLP is calculated on a flat daily rate for each day a participant resides with a SLP provider and is eligible for Medicaid. Payment is not based on the frequency or the type of service provided. The type and frequency of services provided is included in the participant's service plan. Federal Financial Participation is not available for room and board, items of comfort or convenience, or the cost of building maintenance, upkeep and improvement. The methodology by which the cost of room and board are excluded from payments for SLP services is described in Appendix J-5.

Participants in the dementia program receive modified waiver services to meet their care needs. Modified services include: well-being checks three times per day (at least one per shift), at least three scheduled activities per day and alarmed, delayed exit doors as a safety intervention. Dementia units also have secured outdoor areas for use by participants. Participants are evaluated at the time of admission and quarterly thereafter to assess the continued need for the alarmed, delayed exit doors as a safety intervention.

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

There are no limits on the amount, frequency or duration of assisted living services being provided to waiver participants. Supportive Living Program providers must meet the scheduled and unscheduled needs of waiver

participants (89 IL Admin. Code, Chap I , Section 146.230 a). Payment is not made for 24-hour skilled care.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supportive Living Program Provider

### Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Assisted Living

**Provider Category:**

Agency

**Provider Type:**

Supportive Living Program Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Supportive Living Program (SLP) providers are certified by the SMA. A wide range of factors are examined for SLP providers, such as: financial stability, business experience, knowledge and experience in working with the elderly and persons with physical disabilities, record of non compliance with other state programs and property site control. Certification occurs initially when a SLP provider becomes operational and can admit waiver participants. It continues on an annual basis through an on-site review process. Initial certification by the SMA involves the review and approval of resident contracts, policies and procedures, emergency plans and quality assurance plans. Additionally, an on-site visit allows for the examination of approved local inspections, as well as the identification of compliance with required structural components, building maintenance and cleanliness, working building systems, staff background checks, qualifications and training. Final certification requires a review of waiver participant records, apartment observations and interviews. An annual certification review combining the components of the initial and final certification processes is conducted at each SLP provider. Annual certification reviews determine if providers are in compliance with program requirements.

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State Medicaid agency.

**Frequency of Verification:**

The State Medicaid agency verifies provider qualifications at the time of initial certification and during annual on-site annual certification reviews conducted for all Supportive Living Program providers.

**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:

Case management responsibilities are shared by the SMA and Supportive Living Program (SLP) providers. Each entity has a specific role and duties. SLP provider staff is required to complete scheduled assessments (assess.) initially, quarterly and annually. Assess. are also performed if a participant (partic.) experiences a significant change in condition. SLP providers must develop and implement individualized service (svc.) plans based on partic.s' needs and preferences identified in the assess. and voiced by the partic.. Svc. plans are required to be revised when a significant change in condition occurs and reviewed in conjunction with quarterly and annual assess. Additionally, SLP providers must provide assist. with arranging for and coordinating outside svcs. for waiver partic. . Examples include: home health svcs. and physician visits. Ancillary svcs. are another case management component supplied by SLP providers. Staff must arrange transportation for waiver partic. to medical appts. and offer to help with activities like shopping.

The SMA performs case management svcs. by conducting annual level of care determinations for all waiver partic., reviewing partic.s' assessments and svc. plans, addressing problems in svc. provision, monitoring the implementation of svc. plans and observing partic. health and safety.

The SMA staff monitors and provides oversight for SLP case management functions. During annual on-site certification reviews, records of a sample of waiver partic. are reviewed. The SMA verifies partic. assess. were done timely and completed accurately and thoroughly. Svc. plans must be individualized and contain all of the partic.'s needs and preferences. This includes any outside svcs. that are being provided. Progress notes, physician orders and other documentation in the record are also used to verify case management svcs. Partic. interviews are conducted, too.

For partic. enrolled in an MCO, case management for overall health care, including waiver svcs., is the the responsibility of the Plans. MCOs use a variety of tools to collect information about their member's physical, psychological and social health, including health risk screenings, claims data, referrals, service authorizations, transition information, level of care information, information from family members, caregivers, providers and other assess. tools. Health Risk Screenings must be completed within 60 days of enrollment. For HCBS members, the Health Risk Assessment (HRA) must be completed; timeframes vary for the HRA based on whether the member is already receiving HCBS services as a new member (180 days) transitioning from another health plan (90 days) or deemed newly eligible for HCBS services (15 days).

Additional functions that fall under case management for an MCO include providing case management for members and assisting those members in the development and implementation of a care plan. The care coordinator works in partnership with the SLP provider staff to make sure the care plan is comprehensive and person-centered. Care coordinators get support when necessary from a member's Interdisciplinary Care Team, a team made up of clinical and non-clinical staff whose skills and experience complement each other in the oversight of the member's needs.

The care coordinator works with the member to ensure the care plan:

- incorporates the member's medical, behavioral health, social, functional and community-based service needs are addressed
- Identifies short and long term treatment and goals to address the member's needs and preferences and to facilitate monitoring of a member's progress and evolving needs
- includes the opportunity for the member, PCP, other providers, family, etc. to participate and provide input into the

care plan

--identifies risks, cultural preferences, preferred characteristics and language, living arrangements, barriers, community resources, desired outcomes, etc.

## 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 Illinois Health Care Worker Background Check Act [225 ILCS 46](HCWBC Act) requires unlicensed employees of Supportive Living Program (SLP) providers with duties that involve or may involve contact with waiver participants, or access to the living quarters or the financial, medical or personal records of participants, to undergo a criminal background check. The 89 IL Adm in. Code Chap I, Section 146.235(l) of the SLP Rules states, "The SLF shall ensure that all employees who have or may have contact with residents or have access to the living quarters or the financial, medical or personal records of residents undergo a criminal history background check that conforms to the Health Care Worker Background Check Act [225 ILCS 46]. No SLF shall knowingly hire, employ or retain any individual in a position with duties involving contact with residents, access to resident living quarters or access to the financial, medical or personal records of residents, who has been convicted of committing or attempting to commit one or more of the offenses defined under the Health Care Worker Background Check Act unless that individual has obtained a waiver issued by the Department of Public Health. An SLF may conditionally employ an applicant for up to three months pending the results of the criminal history record check".

The HCWBC Act requires fingerprint background checks be completed to identify disqualifying convictions in the State of Illinois. There is no time limit on the background check; any crime committed as an adult is included. Additionally, SLP providers must check sex offender and other criminal registries for all new employees, even those who have already had a qualifying background check. Prior to beginning employment, all unlicensed staff must be checked on the Health Care Worker Registry (Registry), which is maintained by the Illinois Department of Public Health. The Registry identifies if an individual has any disqualifying convictions that would prohibit them from working in a health care setting as defined in the HCWBC Act. If an individual is not listed on the Registry, he or she must go to a State contracted vendor to have their fingerprints collected. The fingerprints are then forwarded to the Illinois State Police. The Illinois State Police updates the Registry and employers are notified of the results. If an individual is convicted of a disqualifying offense after they are hired, the Illinois State Police updates the Registry and the employer is notified. Additionally, certified nurse aides are fingerprinted and added to the Registry as part of their certification.

Licensed staff employed by the SLP provider, including nurses and dietitians, must have proof of current licensure in the State of Illinois. Background checks for these individuals occur at the time of licensing and is overseen by the Illinois Department of Financial and Professional Regulation. SLP providers must maintain a copy of the current license for all licensed staff.

Annual on-site certification reviews are performed by the SMA for each SLP provider. The review includes verifying documentation of Registry and criminal background checks for 100% of employees hired since the previous review. This includes verifying termination of any individuals with disqualifying convictions.

Compliance with the HCWBC Act can also be reviewed during on-site complaint investigations.

- 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 Health Care Worker Background Check (HCWBGC) Act [225 ILCS 46] requires unlicensed health care employees, including those employed by a Supportive Living Program (SLP) provider who have access to waiver participants, their apartments or their financial or medical records, to be checked on the Illinois Department of Public Health's (IDPH) Health Care Worker Registry prior to beginning employment. If the Registry indicates a fingerprint background check has not been completed, the potential employee must have their fingerprints collected. Once results are received, the information is forwarded electronically to the SLP provider and the Registry is automatically updated. If a required Registry check reveals a potential employee has a disqualifying criminal conviction and has not received a waiver from the IDPH, he/she cannot be employed by the SLP provider.

If a prospective employee does not have a current finger print check listed on the Registry, he/she must have their fingerprints collected within 10 business days of signing a designated authorization form. The authorization form must be signed prior to beginning employment. If the fingerprints are not collected within 10 days, the employee must be suspended. If fingerprints are not collected within 30 days, employment must be terminated.

The Department of Financial and Professional Regulation maintains licenses for professional staff, such as nurses and dieticians, and maintains a listing of these persons including current licensure status and any disciplinary actions. All licensed staff must have a current license with the State of Illinois.

Annual on-site certification reviews performed by the SMA at each SLP provider includes examining documentation of Registry checks and active licenses for employees hired since the previous review.

If an employee does not have fingerprints collected timely, the SMA instructs the provider to immediately remove the employee from the schedule until his/her fingerprints are collected. The employee must provide verification of the collection of their fingerprints before returning to work.

## 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).**
  - i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Assisted Living	

- ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

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

89 IL Adm in. Code, Section 146.210 outlines structural requirements for Supportive Living Program (SLP) providers that ensure a home-like setting for waiver participants. For instance, minimum square footage requirements for apartments ensure participants have comfortable living spaces. Each apartment

must have a private bath, living, sleeping, cooking and dining areas. Additionally, each apartment must have a door that locks from the inside and individually controlled heating and cooling. Participants' kitchen areas must include a refrigerator, sink, stove or microwave for cooking and an area for dining. There must also be wiring for telephone and access to cable television or a master antenna. Participants are free to decorate their apartments to reflect their individual taste and style. Additionally, all residents have their own private apartment unless they choose to share a double occupancy apartment.

Common areas are also required in SLP settings to encourage and support participant socialization. Common areas may include private dining rooms, libraries, computer rooms, outside garden/patio areas, family rooms and chapels. Participant laundry rooms are required as well so that that participants may do their own laundry, if they choose. Common areas must be available for participants' use at any time.

Participants can come and go from their apartments and from the building. Note the dementia program has delayed egress. See Appendix G-2 Restrictive Interventions for more information. Additionally, participants are allowed visitors of their choosing at any time, including those in the dementia program.

Access to the larger community is available in the SLP setting. Participants may have their own vehicles with which to access the community. SLP providers may have transportation available or transportation may be available via public transit, local senior or disability advocacy groups or a private transportation company. Shopping trips are arranged at least weekly. Other scheduled activities may include: musical events, religious services, educational opportunities, charity/volunteer opportunities, sporting events, shopping, restaurants, museum trips, scenic drives and outdoor activities. Waiver participants are encouraged to provide input regarding community activities based on their preferences. SLP provider staff also encourage individual community participation, such as volunteering or opportunities for learning. The required comprehensive assessment also includes a section to identify a person's individual interests. Residents are able to access the community and participate in any community activities/events they wish. Additionally, community members are invited into SLP settings. Medical professionals provide information on health and wellness, children's groups provide musical and social entertainment. Faith-based groups and musical entertainers are also common guests.

Opportunities for community involvement are communicated to participants both in writing through activity calendars and newsletters, as well as verbally by staff.

The SMA is responsible for identifying restrictive interventions. Oversight activities occur during on-site visits, including annual certification reviews, complaint investigations, scheduled technical assistance visits and unannounced monitoring visits.

During on-site annual certification reviews, SMA staff reviews participant records and also interviews a representative sample of participants. Participants are asked if they have been informed and are aware of their rights. They are also asked about their satisfaction with the care they receive and if they know to whom they may register complaints. Additionally, during the record review, SMA staff has the opportunity to identify the use of restrictive interventions.

The use of restrictive interventions can also be brought to the SMA's attention at any time via the toll-free complaint hotline, email or written correspondence. Anyone, including participants, their families and provider staff, may register a complaint. Furthermore, the State Long Term Care Ombudsman Program would inform the SMA if staff became aware of or suspected the use of restrictive interventions by a SLP provider. SMA staff must perform on-site investigations in response to complaints received.

SMA staff may conduct scheduled and unscheduled visits for the purposes of monitoring and providing technical assistance to Supportive Living Program (SLP) providers. These visits offer another opportunity for SMA staff to detect the use of restrictive interventions.

If an SLP provider was using restrictive interventions, the SMA would issue a finding of non-compliance. The SLP provider has 30 days to develop and implement a plan of correction from the date written notification of the non-compliance is issued. SMA staff performs an on-site follow-up review to verify the use of restrictive interventions is no longer being practiced. If non-compliance persists after a second follow-up review, the SMA could impose sanctions, including suspending or terminating the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff would assist waiver participants in identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a participant's health or safety was threatened by the use of restrictive interventions, the SMA could also issue a notice of immediate jeopardy. If a participant is at risk at the time of the on-site

review, SMA staff remains at the SLP provider until the area of non-compliance associated with the immediate jeopardy has been abated. Immediate jeopardy also requires the SLP provider to submit and implement a plan of correction within ten days of receipt of the findings. SMA staff performs an on-site follow-up review to verify that remediation has occurred and that the SLP provider is in compliance with administrative rules. If non-compliance is identified, the SMA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants in identifying possible relocation options, including transferring to another SLP provider.

Dementia program participants' safety needs are met with a service intervention of alarmed, delayed exit doors. When the door's release bar is pushed, an alarm sounds. The door will open if the bar is pushed for several continuous seconds. Dementia participants have the freedom to move within the dementia care setting, including access to secured outdoor common space.

Participation in the dementia program is voluntary. The participant, his/her physician, family and dementia program staff collaborate to determine if the dementia program is a beneficial setting. The need for extra supervision is based on a participant's individual characteristics and needs for care and support. All dementia participants must have an elopement risk assessment completed prior to admission and quarterly thereafter by a registered nurse to determine if alarmed, delayed exit doors are a necessary safety intervention. If a participant is assessed to no longer require this intervention, SLP provider staff discusses a different community placement with the participant and his/her designated representative. SMA staff review elopement risk assessments during on-site certification reviews for all participants.

Dementia program participants are able to leave the dementia care setting at any time with staff, family or other designated individuals. SLP provider activities includes options both on-site and in the larger community. Dementia participants may also have visitors at any time. Visits by family and friends are encouraged and do not have to be prearranged with the SLP provider. SLP provider staff is available 24 hours per day to allow visitors access to the building.

SMA staff completes on-site annual certification reviews for the dementia program. SMA staff verifies that participants have been appropriately assessed for the needed safety intervention of alarmed, delayed exit doors. They also confirm assessments were timely, complete and accurate. Participant access to common areas is also verified. If program non-compliance is identified, the process outlined above for SLP providers is followed.

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Assisted Living

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Assisted Living	<input checked="" type="checkbox"/>

**Facility Capacity Limit:**

300

**Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>

Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

## Appendix C: Participant Services

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

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

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

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

- Self-directed**
- Agency-operated**

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

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**

- The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- Other policy.**

Specify:

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The SMA does not limit the type of provider that may apply to the Supportive Living Program (SLP). An extensive process is utilized by the SMA to review applications from providers wishing to participate in the SLP. Provider qualifications are published in Department rules (89 IL Adm. Code, Chap I, 146.215) and are located at the Department's website.

To ensure quality services for waiver participants, the SMA employs a thorough review process for applicants. Interested providers must submit an application and may undergo an in-person interview with SMA staff. Basic information is collected on the application, such as: provider name, planned provider/building name, location, number of apartments and proposed number of residents. Other detailed information included in the application process and examined by the SMA includes:

- financial background and stability
- business experience/background
- knowledge and experience with providing services to the elderly and people with physical disabilities
- operating history with other health care programs
- record of non-compliance with state programs
- knowledge of requirements of the Supportive Living Program, its purpose and its goals
- strategic plan
- architectural drawings
- phase-one environmental study
- market feasibility
- criminal background/Medicare/Medicaid disbarment

Other state agencies, such as the Department on Aging, Department of Human Services and the Illinois Housing Development Authority may also be consulted during the review process. These agencies offer additional information regarding provider qualifications, service history and market area information.

An internal review of the application occurs simultaneously across several divisions of the SMA, with the agency's SLP coordinators overseeing distribution, tracking, review and recommendations returned to the SMA's Bureau of Long Term Care for processing. Once this portion of the review is completed, the applicant may be contacted to schedule a face-to-face interview. Questions related to experience with providing long term care or similar services or programs, familiarity with the SLP waiver and its services and overall plans for the proposed project are posed to the applicant.

Once an application is approved to proceed towards certification, the applicant is notified in writing by the SMA. The SMA may withdraw approval of an approved SLP application if the applicant fails to become operational within 24 months after the approval. Applicants are allowed to request extensions to this operational deadline.

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

## 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:**

**Number/percent of Supportive Living Program provider applicants that met certification requirements prior to enrollment with Medicaid. Numerator: Number of Supportive Living Program provider applicants that met certification requirements prior to enrollment with Medicaid. Denominator: Total number of Supportive Living Program provider applicants.**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number/percent of enrolled Supportive Living Program providers that continued to maintain certification annually. Numerator: Number of enrolled Supportive Living Program providers that maintain certification annually. Denominator: Total number of enrolled Supportive Living Program providers receiving annual certification reviews.

**Data Source (Select one):**

Provider performance monitoring

If 'Other' is selected, specify:

Responsible Party for data	Frequency of data collection/generation	Sampling Approach (check each that applies):
<input type="text"/>	<input type="text"/>	<input type="text"/>

<b>collection/generation</b> <i>(check each that applies):</i>	<i>(check each that applies):</i>	
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

- 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:**

**Only licensed providers; no need for measures for Sub-assurance B.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Not applicable. See performance measure explanation.**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: N/A	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: N/A
	<input checked="" type="checkbox"/> Other Specify: N/A	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: N/A	<input type="checkbox"/> Annually

<input type="checkbox"/> Continuously and Ongoing
<input checked="" type="checkbox"/> Other Specify: N/A

- 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:**

Number/percent of MCOs that offered training as required by policy. Numerator: Number of MCOs that offered training as required by policy. Den: Total number of MCOs reviewed.

**Data Source (Select one):**

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/> ^ v
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/> ^ v
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/> ^ v
	<input type="checkbox"/> Other Specify: <input type="text"/> ^ v	

**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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number/percent of certified dementia program Supportive Living Program providers that offered training as required by Department policy. Numerator: Number of certified dementia program Supportive Living Program providers that offered training as required by Dept. policy. Denominator: Total number of dementia program Supportive Living Program providers receiving annual certification reviews.

**Data Source (Select one):**

Training verification records

If 'Other' is selected, specify:

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

		<input type="text"/> <input type="button" value="^"/> <input type="button" value="v"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/> <input type="button" value="^"/> <input type="button" value="v"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/> <input type="button" value="^"/> <input type="button" value="v"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/> <input type="button" value="^"/> <input type="button" value="v"/>

**Performance Measure:**

Number/percent of certified Supportive Living Program providers that offered training as required by Department policy. Numerator: Number of Supportive Living Program providers that offered training as required by Department policy. Denominator: Total number of Supportive Living Program providers receiving annual certification reviews.

**Data Source (Select one):**

Training verification records

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/> <input type="button" value="^"/> <input type="button" value="v"/>

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.  
The State Medicaid agency (SMA) is responsible for ensuring individual problems are resolved.

Potential Supportive Living Program (SLP) providers found not to meet requirements for initial certification are given an opportunity to make changes that would allow them to be compliant. If program rule requirements are not met, the Department does not enter into a Medicaid provider agreement with the provider.

When SLP providers that are already certified and providing waiver services receive findings of non-

compliance, a plan of correction (POC) must be developed to address the problem area(s). The POC must be submitted to the SMA within fourteen days of receipt of the findings and implemented within thirty days. SMA staff performs a follow-up on-site review to determine if remediation has occurred. If non-compliance is still identified, the SLP provider receives a form outlining the current non-compliance area(s) and is given another thirty days to correct. Continued non-compliance during a second onsite follow-up review by SMA staff results in sanctions, including but not limited to mandatory in-servicing for staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with relocation options, including transferring to another SLP provider. The same procedures are followed for the dementia program.

If an MCO is found not to have provided training as required, remediation would occur within 60 days in the form of training being completed. Upon receipt of findings of lack of training completion, the SMA directs the External Quality Review Organization (EQRO) to initiate a Corrective Action Plan (CAP) to the MCO, requiring remediation within 60 days. The EQRO requires the MCO to submit evidence of training, including but not limited to agendas, training materials, and attendance rosters. The EQRO maintains oversight of the MCO's response to ensure that training is provided within 60 days of the MCO's receipt of the CAP. The EQRO reviews the documentation to ensure compliance with SLP training requirements and submits the CAP findings to the SMA, including any outstanding issues that were not addressed. The SMA determines actions on non-remediated findings, which may include MCO removal of staff from SLP case management until training is completed or sanctions. The SMA directs the EQRO to continue follow-up with the MCO on non-remediated findings until the actions are complete, which is limited to 60 days from the date of the SMA action of non-remediated findings.

The SMA's contracts with MCOs include termination rights. If the MCO fails to perform to the SMA's satisfaction on any material requirement of the contract or if the MCO is in violation of a material provision of the contract, the SMA has the right to terminate the contract. The SMA provides a written notice to the MCO requesting that the breach or non-compliance be remediated within a timeframe determined by the SMA. The SMA allows at least 60 days for the MCO to come into compliance and if that does not occur, the SMA can terminate the contract.

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

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

- No
- Yes

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

**Appendix C: Participant Services**

**C-3: Waiver Services Specifications**

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

**Appendix C: Participant Services**

**C-4: Additional Limits on Amount of Waiver Services**

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

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

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

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

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

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

**Other Type of Limit.** The State employs another type of limit.  
*Describe the limit and furnish the information specified above.*

**Appendix C: Participant Services**

**C-5: Home and Community-Based Settings**

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

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

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

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

89 IL Adm in. Code, Section 146.210 outlines structural requirements for Supportive Living Program (SLP) providers that ensure a home-like setting for waiver participants. For instance, minimum square footage requirements for apartments ensure participants have comfortable living spaces. Each apartment must have a private bath, living, sleeping, cooking and dining areas. Additionally, each apartment must have a door that locks from the inside and individually controlled heating and cooling. Participants' kitchen areas must include a refrigerator, sink, stove or microwave for cooking and an area for dining. There must also be wiring for telephone and access to cable television or a master antenna. Participants are free to decorate their apartments to reflect their individual taste and style. Additionally, all residents have their own private apartment unless they choose to share a double occupancy apartment.

Common areas are also required in SLP settings to encourage and support participant socialization. Common areas may include private dining rooms, libraries, computer rooms, outside garden/patio areas, family rooms and chapels. Participant laundry rooms are required as well so that that participants may do their own laundry, if they choose. Common areas must be available for participants' use at any time.

Participants can come and go from their apartments and from the building. Note the dementia program has delayed egress (see below). Additionally, participants are allowed visitors of their choosing at any time, including those in the dementia program.

Access to the larger community is available in the SLP setting. Participants may have their own vehicles with which to access the community. SLP providers may have transportation available or transportation may be available via public transit, local senior or disability advocacy groups or a private transportation company. Shopping trips are arranged at least weekly. Other scheduled activities may include: musical events, religious services, educational opportunities, charity/volunteer opportunities, sporting events, shopping, restaurants, museum trips, scenic drives and outdoor activities. Waiver participants are encouraged to provide input regarding community activities based on their preferences. SLP provider staff also encourage individual community participation, such as volunteering or opportunities for learning. The required comprehensive assessment also includes a section to identify a person's individual interests. Residents are able to access the community and participate in any community activities/events they wish. Additionally, community members are invited into SLP settings. Medical professionals provide information on health and wellness, children's groups provide musical and social entertainment. Faith-based groups and musical entertainers are also common guests.

Opportunities for community involvement are communicated to participants both in writing through activity calendars and newsletters, as well as verbally by staff.

The SMA is responsible for identifying restrictive interventions. Oversight activities occur during on-site visits, including annual certification reviews, complaint investigations, scheduled technical assistance visits and unannounced monitoring visits.

During on-site annual certification reviews, SMA staff reviews participant records and also interviews a representative sample of participants. Participants are asked if they have been informed and are aware of their rights. They are also asked about their satisfaction with the care they receive and if they know to whom they may register complaints. Additionally, during the record review, SMA staff has the opportunity to identify the use of restrictive interventions.

The use of restrictive interventions can also be brought to the SMA's attention at any time via the toll-free complaint hotline, email or written correspondence. Anyone, including participants, their families and provider staff, may register a complaint. Furthermore, the State Long Term Care Ombudsman Program would inform the SMA if staff became aware of or suspected the use of restrictive interventions by a SLP provider. SMA staff must perform on-site investigations in response to complaints received.

SMA staff may conduct scheduled and unscheduled visits for the purposes of monitoring and providing technical assistance to Supportive Living Program (SLP) providers. These visits offer another opportunity for SMA staff to detect the use of restrictive interventions.

If an SLP provider was using restrictive interventions, the SMA would issue a finding of non-compliance. The SLP provider has 30 days to develop and implement a plan of correction from the date written notification of the non-compliance is issued. SMA staff performs an on-site follow-up review to verify the use of restrictive interventions is no longer being practiced. If non-compliance persists after a second follow-up review, the SMA could impose sanctions, including suspending or terminating the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff would assist waiver participants in identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a participant's health or safety was threatened by the use of restrictive interventions, the SMA could also issue a notice of immediate jeopardy. If a participant is at risk at the time of the on-site review, SMA staff remains at the SLP provider until the area of non-compliance associated with the immediate jeopardy has been abated. Immediate jeopardy also requires the SLP provider to submit and implement a plan of correction within ten days of receipt of the findings. SMA staff performs an on-site follow-up review to verify that remediation has occurred and that the SLP provider is in compliance with administrative rules. If non-compliance is identified, the SMA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants in identifying possible relocation options, including transferring to another SLP provider.

Dementia program participants' safety needs are met with a service intervention of alarmed, delayed exit doors. When the door's release bar is pushed, an alarm sounds. The door will open if the bar is pushed for several continuous seconds. Dementia participants have the freedom to move within the dementia care setting, including access to secured outdoor common space.

Participation in the dementia program is voluntary. The participant, his/her physician, family and dementia program staff collaborate to determine if the dementia program is a beneficial setting. The need for extra supervision is based on a participant's individual characteristics and needs for care and support. All dementia participants must have an elopement risk assessment completed prior to admission and quarterly thereafter by a registered nurse to determine if alarmed, delayed exit doors are a necessary safety intervention. If a participant is assessed to no longer require this intervention, SLP provider staff discusses a different community placement with the participant and his/her designated representative. SMA staff review elopement risk assessments during on-site certification reviews for all participants.

Dementia program participants are able to leave the dementia care setting at any time with staff, family or other designated individuals. SLP provider activities includes options both on-site and in the larger community. Dementia participants may also have visitors at any time. Visits by family and friends are encouraged and do not have to be prearranged with the SLP provider. SLP provider staff is available 24 hours per day to allow visitors access to the building.

SMA staff completes on-site annual certification reviews for the dementia program. SMA staff verifies that participants have been appropriately assessed for the needed safety intervention of alarmed, delayed exit doors. They also confirm assessments were timely, complete and accurate. Participant access to common areas is also verified. If program non-compliance is identified, the process outlined above for SLP providers is followed.

## Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:  
Individual Support Plan (ISP)

- 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)
- Case Manager (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

- 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:*

Waiver participants (partic.) may choose among Supportive Living Program (SLP) providers (prov.). By selecting a SLP prov. and executing a resident contract (RC), the partic. accepts the services (svcs) that the SLP prov. is obligated to provide under the SLP. This includes: assistance with medication, ADLs, IADLs, routine health assessments, well-being checks, social and health promotion activities, 24 hour staff, emergency call system and arranging outside services. It also includes the development of the individual support plan (ISP) and the delivery of svcs identified in the plan which are required to be supplied by the SLP prov. Svcs. provided by an outside entity must also be documented in the plan. The RC must include information regarding the svcs. the partic. will receive from the SLP prov. that are covered under Medicaid (89 IL Adm Code (IAC), Chap. I, Section 146.240(b)(1)). A partic. is free to cancel a RC and transfer to another svc. prov. or choose to participate in another program at any time. The option to end the RC is included in the RC approved by the SMA.

For svcs. not provided by the waiver, such as physical therapy, a partic. may select the prov. of his/her choice. Additionally, SLP prov. are required to assist partic. with obtaining these svcs. (89 IAC, Chap I, Section (Sec.) 146.250(e)(7)). The ISP must include coordination and inclusion of svcs. being delivered to a partic. by an outside entity (89 IAC, Chap I, Sec. 146.245(d)), as well as any svcs. the partic. chooses to decline (89 IAC, Chap I, Sec. 146.250(e)(6)). Prov. cannot maintain SLP svcs. in combination with home health, home care, nursing home, hospital, residential care setting, congregate care setting or other type of residence or svc. agency unless those settings and svcs. are licensed, maintained and operated as separate and distinct entities (89 IAC, Chap I, Sec. 146.215(i)). The SMA verifies distinction of svcs. annually.

Partic. have the right and are strongly encouraged to participate in the development of their ISP (89 IAC, Chap I, Sec. 146.245(d) and 146.250(e)(16)). A designated representative (rep.) is involved at the request of the partic. and for partic. who are not able to be involved in the process due to their physical or cognitive status. Partic. may also include others in the ISP development (89 IAC, Chap I, Sec. 146.245(d)). Another right related to a partic.'s ISP is the option to refuse svcs., so long as others are not harmed by the refusal (89 IAC, Chap I, Sec. 146.250(e)(6)). The SLP prov. must explain the potential consequences to the partic. and/or his designated rep. and include the refusal in the ISP.

A registered nurse (RN) is responsible for the development and implementation of the plan (89 IAC, Chap I, Section I 46.245(d)). As a requirement of licensure, the RN must have completed a state approved educational course, which includes patient care planning. Formal curriculum training has been provided to SLP prov. staff. The RN may also provide other SLP waiver svcs. In addition to the ISP, an RN is responsible for the initial assessment (a licensed practical nurse may also complete), comprehensive resident assessment, and quarterly evaluations (89 IAC, Chap I, Sec. 146.245(b)(c) and (e)). Other nursing services include: medication set-up, medication administration and episodic and intermittent health promotion or disease prevention (89 IAC, Chap I, Sec. 146.230(b)(1-4)). Nursing svcs. must be provided in accordance with the Nursing and Advanced Practice Nursing Act (225 ILCS 65) (89 IAC, Sec. 146.230(b)(5)).

The SMA provides oversight of the plan development process and delivery of svcs. by reviewing 100% of new

partic.' records and a rep. sample of continuing partic.s' records annually. ISPs are among the documents examined for timeliness, thoroughness and accuracy, as well as signatures of the RN and partic. A review of the partic.'s comprehensive assessment and their interview information is compared to the ISP to ensure all identified goals, preferences and needs are included. Additional documentation reviewed may include MD orders, nursing notes and medication orders and also partic. interview. The ISP must identify desired outcomes, partic. strengths and needs and steps to achieve desired outcomes, along with the person/staff/parties involved with the services and supports. Any svcs.refused by the partic.must also be noted. SMA staff also interviews a rep. sample of partic. to verify their needs and preferences are being met.

These requirements also apply to partic. in the dementia program and those enrolled in an MCO.

Additionally, for partic. enrolled in an MCO, the MCO case management team reviews the comprehensive assessment and ISP to verify that all the partic.'s needs and preferences are identified. The MCO works with the SLP prov. staff to incorporate any changes to the ISP. The SMA is responsible for monitoring program compliance for the comprehensive assessment and the plan for partic. enrolled in a MCO. The MCO assists the partic. with arranging for and coordinating outside svcs. These svcs.are communicated to SLP prov. staff for inclusion in the ISP.

The MCOs' case management team completes an assessment to elicit comprehensive information from the partic. The assessment aids in the development of an overall health and support service plan that includes community health svcs., along with the waiver svcs. identified in the ISP developed by the SLP provider's RN staff. The components in the assessment used by the Plans include but are not limited to cognitive/emotional, ADLS, IADLs, behavioral health, medication, living supports, environmental conditions and health care information. Partic. and their designated representative are involved in the development of the service plan. Through the assessment and care planning process, the partic.s' goals and strengths and barriers to achieving these goals are identified.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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

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

A written resident contract/lease agreement that includes information regarding SLP services must be entered into by each waiver participant (89 IL Admin. Code, Chap I, Section 146.240(b)(1), "The resident contract shall include, but not be limited to, the following: Information regarding SLF services the resident will receive that are covered under the Medical Assistance Program"). This contract is signed prior to the time of admission, thus in advance of the development of the individual support plan (ISP). The contract provides the participant and/or his/her representative with information regarding the services that are available through the SLP waiver. The SMA must review and approve all resident contracts. This includes verifying available waiver services are identified in the contract. The contract must be in language and format understandable to the participant and his/her designated representative. The resident contract/lease agreement must also include a statement that the SLP provider will comply with all applicable federal, State and local laws and regulations (89 IL Admin. Code, Chap I, Section 146.240 (b) (4)).

A list of waiver participant rights, established by the SMA, must be provided to each participant with the resident contract (89 IL Admin. Code, Chap I, Section 146.240(b)(7), "The resident contract shall include, but not be limited to, the following: A list of the resident rights as stated in Section 146.250"). Among these is the right to all housing and services for which he or she has contracted and paid (89 IL Admin. Code, Chap I, Section 146.250(e)(2), "All housing and services for which he or she has contracted and paid"). Additionally, it is the right of a waiver participant to be involved in the development, implementation and review of his/her service plan (89 IL Admin. Code, Chap I, Section 146.250(e)(16) "Each resident shall have the right to: Participate in the development, implementation and review of his or her service plans").

SLP requirements also ensure that limited English speaking participants have the opportunity for meaningful communication that allows for equal access to benefits and services (89 IL Admin. Code, Chap I, Section 146.215(n), "The SLP shall ensure that limited English speaking residents have meaningful and equal access to benefits and services"), including information regarding available services, resident rights and development of their individual service plan (ISP). A copy of the ISP must be given to the participant, his/her designated representative and whomever else they choose in a language and format that is understandable to them.

Participant rights established by the SMA give the participant the right to make and act upon decisions; participate in the development of the ISP; and designate or accept a representative to act on the participants' behalf. The 89 IL Admin. Code, Chap I, Section 146.250(e)(3) states, "Have his or her records kept confidential and released only with his or her consent or in accordance with applicable law". Additionally, the 89 IL Admin. Code, Chap I, Section 146.250(e)(15) requires a participant to "Make and act upon decisions (except those decision delegated to a legal guardian) so long as the health, safety and well-being of others are not endangered by his or her actions". The 89 IL Admin. Code, Chap I, Section 146.250(e)(16) states the participant shall, "Participate in the development, implementation and review of his or her service plans". Finally, the 89 IL Admin. Code, Chap I, Section 146.250(e)(19) ensures the right to, "Designate or accept a representative to act on his or her behalf."

Participants are encouraged to include individuals of their choice in the service planning process. SLP provider staff assist participants by scheduling ISP development meetings at a time and location convenient for the participant and others they designate. Input from participants regarding their goals, strengths and needs are among the things discussed. This includes both waiver and outside services. Refusal of services are also identified in the ISP. SLP provider staff reviews the possible consequences of the refusal with the participant prior to documenting in the ISP. The ISP form requires the participant's signature or his/her designated representative, if applicable, and may also be signed by others the participant chooses to involve in the development of the ISP.

All of the above also applies to participants in the dementia program and those enrolled in a MCO.

## **Appendix D: Participant-Centered Planning and Service Delivery**

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

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

The individual support plan (ISP) is personalized and capsulates the goals, needs and preferences of each participant. Its development is the result of a collaboration by the participant, his/her designated representative and others of the participant's choosing and Supportive Living Program (SLP) provider staff. Physicians and outside agencies providing non-waiver services may also be included. Each ISP team member provides input that assists with the development of the ISP. The ISP is not a static tool, but is always changing to reflect the current needs, goals and preferences of the participant. Waiver services are provided by SLP provider staff. Waiver participants are assisted by SLP staff with arranging non-waiver services available through other entities. These services must be included in the participant's ISP. The SLP provider's registered nurse (RN) staff is responsible for coordination of care for waiver and non-waiver services. The ISP can also include goals in personal areas, such as employment, learning opportunities, personal time and volunteer activities, as identified by the participant.

- (a) Who develops the plan, who participates in the process and timing of the plan?

The SLP provider's RN is responsible for the participant's assessments and assists the participant with the development of the ISP. Individuals involved with the completion of the ISP are the participant and people who have knowledge of the participant and his/her needs and preferences. This includes the participant, his/her family, friends, designated representative, any other individuals selected by the participant, other healthcare providers and SLP provider staff.

The SLP nursing staff is responsible for the timely completion of plans. An initial ISP is required within 24 hours of a participant's admission (89 IL Adm in. Code, Chap I, Section 146.245(b), "The SLF shall complete an initial assessment and service plan within 24 hours after move-in that identifies needs and potential immediate problems"). Initial plans are implemented during the period of time between admission and the development and implementation of the ISP. The ISP is due within 7-21 days of admission and includes a more in-depth discussion with the participant, a comprehensive assessment and an observation period. Each ISP is unique and individualized for the waiver participant with their input. The ISP is reviewed and updated at the request of the participant, in conjunction with required quarterly evaluations and as dictated by changes in a participant's condition, needs or preferences. The 89 IL

Admin. Code, Chap I, Section 146.245(d) states, "The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in resident needs or preferences". ISPs are developed at a time and location convenient for the participant, his/her designated representative, others the participant chooses to involve and SLP staff.

The requirements are the same for the dementia program and those enrolled in an MCO. MCOs also receive a copy of the ISP.

(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.

**Standardized Interview:**

A standardized interview developed and administered by the SLP provider staff that is geared toward the participant's service needs must be done at or before the time of move-in (89 IL Admin. Code, Chap I, Section 146.245(a), "The SLF shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy"). The requirement is the same for the dementia program and those enrolled in an MCO.

**Initial Resident Assessment:**

An initial assessment of the participant and an initial plan are completed within 24 hours after admission (89 IL Admin. Code, Chap I, Section 146.245(b), "The SLF shall complete an initial assessment and service plan within 24 hours after admission that identifies needs and potential immediate problems"). Information is obtained from the participant, designated representative or whomever the participant wishes to include, along with medical records. The comprehensive assessment tool described below, may be used, or a version thereof may be developed by the SLP provider for use as the initial assessment. The initial assessment is not intended to take the place of the comprehensive assessment required within 7-14 days of admission. These initial documents may be completed by someone other than licensed nursing staff, but must be reviewed and signed by either a licensed practical nurse (LPN) or RN within 24 hours of admission. The LPN or RN reviews the initial assessment and other documentation, such as physician orders and medication lists, to verify the assessment adequately reflects the participant's needs and preferences. The requirements are the same for the dementia program and those enrolled in an MCO.

**Comprehensive Assessment:**

A standardized, comprehensive assessment tool required by the SMA is completed for every participant within 7-14 days after admission, annually and in response to a significant change in condition. The comprehensive assessment is designed to capture the participant's strengths, needs, preferences, health status and risk factors. This tool assesses a participant's cognitive patterns, communication patterns, vision patterns, mood and behavior patterns, physical functioning, ADLs and IADLs, continence, disease diagnosis, health conditions, oral/nutritional status, skin condition, activity and interest pursuit patterns and special treatments. It is completed through means of interview of the participant, designated representative and others the participant chooses to involve, caretakers, and any other appropriate entity. SLP staff observation and the review of medical records are also included. Information documented in the comprehensive assessment and information received from the participant is used to develop the ISP. Completion of the comprehensive assessment is the responsibility of the SLP provider RN. The requirements are the same for the dementia program and those enrolled in an MCO.

**Participant Involvement:**

Participants drive the development of the ISP with the support of SLP staff and whomever else they choose to include. During ISP development, participants identify what is important to them, including goals, strengths, needs and preferences. SLP staff support the participant by helping to identify steps to achieve desired outcomes for waiver and non-waiver services and formalizing the plan on the required ISP form. Participants, their designated representative and whomever else they choose, receive a copy of the ISP in a language that is understandable to them. The requirements are the same for participants in the dementia program and those enrolled in an MCO.

**Quarterly Evaluation:**

The quarterly evaluation is completed within 92 days from the previous assessment. This evaluation must include information regarding the participant's current status (89 IL Admin. Code, Chap I, Section 146.245(e), "A quarterly evaluation of the health and behavior status of each resident using a Department designated form shall be completed"). As with the other assessments and the development of the ISP, the participant and his/her designated representative participate in this evaluation. The evaluation form must be signed by the SLP provider nurse and the participant or designated representative. Any changes noted in the quarterly evaluation related to current waiver or

non-waiver services, goals, strengths, needs or preferences are to be included in the ISP. The quarterly evaluation is the responsibility of the SLP provider RN. The requirements are the same for the dementia program and those enrolled in an MCO.

**Elopement Risk Assessment (dementia program ONLY):**

An elopement risk assessment tool designated by the SMA must be completed for every dementia program participant prior to admission and quarterly thereafter. The purpose of the assessment is to determine if the participant requires a safety intervention of alarmed, delayed exit doors. This assessment must be completed by an RN. The participant's need for this safety intervention must be included on the ISP.

**Kitchen Appliance Assessment (dementia program ONLY):**

Prior to admission and quarterly thereafter, an assessment of the participant's ability to safely operate kitchen appliances in their apartment must be completed. This assessment must be completed by an RN. The participant's need for a safety intervention as it applies to kitchen appliances must be included the ISP.

**MOCA or SLUMS Assessment (dementia program ONLY):**

Either the Montreal Cognitive Assessment or the St. Louis University Mental Status assessment must be completed for every dementia program participant within 7-14 days of admission. This assessment must be completed by an RN. These tools allow memory recall and the ability to follow directions to be assessed.

These assessments also apply to participants in the dementia program and dementia care participants who are enrolled in an MCO.

**(c) How the participant is informed of the services that are available under the waiver;**

The resident contract is required to include information regarding the services available to participants under the waiver. The SLP provider must ensure the contract is in a language appropriate for the participant or their representative (89 IL Admin. Code, Chap. I, Section 146.240(f), "The SLF shall ensure that all SLF materials, including the resident contract, shall be in a language appropriate to the resident population"). The contract must also include a listing of resident rights for the SLP (89 IL Adm in. Code, Chap. I, Section 146.240(b)(7). SLP providers are required to submit to the SMA for approval, prior to use, copies of every type of resident contract, thus ensuring waiver services and participant rights are included in the contract (89 IL Adm in. Code, Chap I., Section 146.215(c) (3), "Submit for approval prior to use a model of every type of resident contract to be used by the SLF"). The contract must be signed by the participant or designated representative at or prior to occupancy. Participants also receive a SMA SLP resident rights brochure at the time of admission and annually thereafter during service planning meetings. The requirements are the same for the dementia program and those enrolled in an MCO.

Additionally, participants enrolled in an MCO are informed by the Plan of the covered waiver services at the initial face-to-face visit and annually.

**(d) How the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences;**

By combining information gathered from the participant and others designated by him/her, the comprehensive assessment and medical documentation, the SLP RN is able to assist the participant with the development and implementation of the ISP. Every service provided to the participant, whether supplied by the SLP provider or an outside agency, must be included in the ISP form. The ISP must also include needs, preferences and goals expressed by the participant or his/her designated representative.

The ISP must: (1) Capture what is important to the participant. Examples include: goals, personal interests, cultural and lifestyle considerations and service needs and preferences identified by the participant; (2) Specify a desired outcome(s) for these interests, goals, services, etc.; (3) Identify the participant's strengths as it relates to obtaining the desired outcome; (4) Outline the participant's needs, if any, for achieving or striving to achieve the desired outcome; (5) Steps identified by the participant and ISP team to achieve the desired outcome, including specifying steps which the participant will complete and those to be completed by the SLP provider or other applicable party; and (6) Barriers to achievement of desired outcomes or risks, including education or information provided to the participant regarding the barrier and/or risk.

The ISP process ensures the resident is actively involved and driving the development of the plan. The process requires the identification of participant goals, preferences and needs, timely assessment of the individual and the use of qualified staff to complete and monitor the assessment process and assist with plan development and implementation. The SLP provider RN is responsible for assisting the participant with the development of the ISP.

Participants are also informed of provider choice and receive contact information for the Department on Aging and/or Department of Human Services to receive referral information for other programs available to them, if requested. Choice of provider is documented during the ISP development process.

The requirements are the same for the dementia program and those enrolled in an MCO. The MCO also receives a copy of the ISP for review.

(e) How waiver and other services are coordinated;

The ISP must include the coordination of waiver and non-waiver services being delivered to a participant by the SLP provider or an outside entity (89 IL Admin. Code, Chap I, Section 146.245(d), "This includes coordination and inclusion of services being delivered to a resident by an outside entity"). The coordination of waiver and non-waiver services are accomplished in a variety of ways including, during the completion of required assessments and by communication at any time between the participant and SLP provider staff. Whenever and however the information is learned, it must be incorporated into the ISP.

Participants, designated representatives and whomever else the participant chooses receive a copy of the ISP in a language they can understand. Additionally, information related to providing waiver services and assisting the participant with reaching desired outcomes is shared with relevant SLP provider staff so they may implement the services detailed in the plan according to the participant's needs and preferences. For instance, certified nursing assistants (CNA) may refer to ISPs to obtain information regarding participant preferences when providing assistance with activities of daily living. Licensed nursing staff can use the ISP to include the resident in medication management services. Dietary staff use ISP information to provide food choices for therapeutic diets. Activity staff may use it to identify areas of interest of the participant for activity planning and support of community integration. The SLP provider's RN and management staff are responsible for communicating with other staff regarding the implementation of the ISP, including the participant's choices and preferences. The SLP provider's RN is responsible for ensuring that the participant's ISP is implemented appropriately, including coordination with outside entities.

The same is true for the dementia program and those enrolled in an MCO. For those enrolled in a managed care, MCO staff assist with the arrangement and coordination of non-waiver health care services. The MCO and SLP provider nursing staff work together to ensure all of the participant's needs are being met and services coordinated.

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

The ISP must identify who will assist and support the participant with achieving their desired outcomes for waiver and non-waiver services (89 IL Admin.Code, Chap I, Section 146.245(d)), "The service plan shall include...whether the services will be provided by licensed or unlicensed staff"). During the implementation process of the ISP, the appropriate individuals are notified regarding their responsibilities in providing specific services and support to the participant. The ISP also includes the participant's strengths that will assist with achieving desired outcomes and the steps to achieve they have identified for him/herself. The SLP provider's RN is responsible for assigning responsibilities to implement the plan and to also monitor. The same is true for the dementia program and those enrolled in an MCO. MCO staff also review the ISP to make sure the participant is receiving all of the services and support they need and prefer. ISPs are reviewed at least quarterly, or more often if a change in condition occurs or at the participant's requests.

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

Participants may request a review of their ISP at any time. At a minimum the ISP must be reviewed quarterly. If a participant experiences a significant change in condition, needs or preferences, the ISP must be updated at that time (89 IL Admin. Code, Chap I, Section 146.245(d), "The service plan shall be reviewed and updated in conjunction with the quarterly evaluation or as dictated by changes in the resident's needs or preferences"). The same is true for the dementia program and those enrolled with an MCO.

**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.

Potential risks are to be identified during the required formal assessment processes, during the ISP development and at any time potential risks arise due to a change in the participant's status or preferences. At the time a potential risk becomes known to the SLP provider, the risk must be discussed with the participant and/or the designated representative. The participant's physician, counselor, long term care ombudsman or other applicable party may also be included. The individual support plan (ISP) must identify the risk, document education of the risk to the participant and steps to overcome the risk. The ISP will identify the participant's role and which staff and/or party will be included in addressing the risk. Should the participant choose to refuse assistance in overcoming the risk, this will be documented on the ISP. For those enrolled in an MCO, the MCO will be notified.

Resident rights for the SLP allow the participant to refuse to participate in any service or activity once the potential consequences of such refusal have been explained to the participant or designated representative, so long as others are not harmed by the refusal (89 IL Admin. Code, Chap I, Section 146.250(e)(6), "Each resident shall have the right to refuse to receive or participate in any service or activity once the potential consequences of refusal have been explained to the resident and the resident's representative, if requested by the resident. Refusal shall be documented in the service plan and reviewed no less than quarterly"). The participant may also ask the State long term care ombudsman be present during these discussions. Participants can remain in the SLP provider building foregoing recommended or needed services from the SLP provider or available from others. However, should the participant forgo recommended services, an acknowledgement shall be made that the decision was made against the advice of the SLP provider or other appropriate entities. 89 IL Admin. Code, Chap I, Section 146.245(d) requires that these refused services be documented on the ISP (The service plan shall document any services recommended by the SLP that are refused by the resident").

SLP providers are required to have certified nurse aide staff on-site 24 hours per day to meet participants' scheduled and unscheduled needs. Licensed nursing staff is available on-site and on-call. If a staff person calls off or does not show up for work, on-call staff or other available staff would be required to fill in. The SMA monitors SLP provider staffing during annual on-site certification reviews for all SLP providers and in response to any complaints received. If non-compliance regarding staffing is identified, a finding of non-compliance is cited and the SLP provider must develop and implement a plan of correction within 30 days. In the case of insufficient staffing, the SMA requires the current staff schedule to be remediated while SMA staff is on-site. SMA staff completes an unannounced, on-site follow-up review to determine compliance. If the SLP provider is still out of compliance, another 30 days is allowed to remediate. If a second follow-up review continues to show non-compliance, sanctions are issued, up to and including provider termination. In this case, SMA staff would assist participants with relocation.

This process also applies to participants in the dementia program and those enrolled with an MCO.

**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.

Waiver participants, including those in the dementia program, may choose among any certified SLP providers. Participants enrolled with an MCO may choose any certified SLP provider that contracts with the MCO. Information regarding these providers and services is available through a variety of resources including the Supportive Living Program website and the SMA directly. Additionally, the Illinois Department of Human Services, Family and Community Resource Center caseworkers, who are responsible for accepting Medicaid applications and determining eligibility, may make referrals. The Illinois Department on Aging and its contracted agencies, including Case Coordination Units that perform initial level of care assessments for residents in need of waiver services, may provide information regarding the SLP to potential participants and their families. The Department on Aging also operates

help lines that provide referral information for elderly persons and their families. Additionally, State long term care ombudsman are a resource for participants and supply information regarding providers, services and programs. Contact information for the long term care ombudsman must be posted in each SLP provider building.

For participants enrolled in an MCO, the Plan assists the participant in obtaining information and selecting from among qualified providers of waiver services. The Plans provide information about the available services and service providers to each participant and answer any questions that arise. The Plan assists the participant through the provider network supplying information relevant to the services selected by the member and available in the service area of their choosing. Participants always have first choice of the provider they select to meet their needs. Plans 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 Plans' provider list is available on the Plan's website. There are currently 9 MCOs that have contracts with SLP providers. There have not been any concerns related to access to services by waiver participants.

By selecting a SLP provider and executing a resident contract, the participant accepts the services that the provider is obligated to provide under the SLP waiver. A participant is free to cancel a resident contract and transfer to another service provider or choose to participate in another program at any time. This is explained annually during the service planning meeting and referral contact information is provided to the participant, if requested. This applies to participants in the dementia program and those enrolled in an MCO as well.

## 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):

Supportive Living Program (SLP) providers must develop individual support plans (ISP) in accordance with SMA requirements. (1) The participant, designated representative and any individuals the participant chooses must be involved in the development of the ISP to identify goals, desired outcomes, needs, strengths, preferences and lifestyle and cultural considerations. (2) The standardized comprehensive resident assessment completed by the SLP provider RN must be used to help identify participant strengths, needs and health care issues. (3) The ISP must be completed in a SMA designated format that identifies desired outcomes, participant strengths, needs and steps to achieve desired outcomes, along with any barriers and risks. The ISP must identify steps the participant will take to achieve desired outcomes, as well as services and supports supplied by the SLP provider or other applicable party.

The SMA conducts annual on-site certification reviews at all SLP providers. This includes a review of ISPs for a representative sample of all continuing waiver participants and 100% review of new waiver participants. SMA staff completes an in-depth record review that includes, but is not limited to the ISP, comprehensive assessment, quarterly evaluations, nursing notes, medication management service records, incident reports and physician orders. SMA staff also interview a representative sample of participants. This comprehensive review allows SMA staff to ascertain whether the ISP meets program requirements, that required waiver services are being provided and participant choices and preferences are included. SMA staff also determines if assessments and ISPs were completed timely and that any changes in condition and participant preferences were captured.

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

## 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 also required to maintain waiver 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 SMA is responsible for monitoring service plan implementation and the health and welfare of waiver participants, including those in the dementia program. On-site monitoring is performed annually, at a minimum.

As part of the monitoring process, comprehensive record reviews are conducted annually for a representative sample of continuous waiver participants at all SLP providers and 100% of new waiver participants. This monitoring involves an in-depth record review that includes, but is not limited to: the individual support plan (ISP), comprehensive assessment, quarterly evaluations, medication management service records, incident reports and physician orders. SMA staff also meet in person with waiver participants in the representative sample and conduct a standardized interview that includes questions regarding services received and choices and preferences.

SMA staff ensure participants' comprehensive assessments, which are used to assist with the development of the ISP, are completed within required timeframes, accurately reflect participant needs, strengths, health conditions and service provision and that any significant changes in condition are documented.

The ISP must include input from the participant and designated representative as identified by the inclusion of participant goals, preferences, strengths and declined services. The ISP must incorporate information from the comprehensive assessment, physician orders and any non-waiver services supplied by an outside provider. Nursing notes, progress notes, medication management service records and other documents are examined to substantiate that services are being provided.

The health and safety of waiver participants is verified by confirming that all required and preferred services are included in the ISP, that risks are identified and mitigated, participants' physicians are notified of changes in condition and that required SMA reporting takes place as required by administrative rule.

SMA staff also document that the ISP is signed by the participant or designated representative, indicating their involvement with the development of the plan and their choice in selecting the SLP provider to supply required waiver services and/or assist with coordination of non-waiver services. In order to determine if the ISP has been developed accurately and is being fully implemented to meet all of the services needed and preferred by the participant, the SMA reviews the various documents noted above in the participant's record, in addition to participant interviews.

This thorough review allows SMA staff to ascertain whether or not all of the participant's needs and preferences and goals have been identified and are being met through services and supports outlined in the ISP. For instance, if a review of nursing notes indicates a participant has recently fallen several times, SMA staff expect the ISP to contain

information related to fall-prevention services. Additionally, if the participant's record contains a physician order for physical therapy, SMA staff would verify these outside services were obtained and included in the ISP.

If a participant experienced a significant change in condition, SMA staff makes sure the change was noted in the ISP. They also verify that the participant's physician and designated representative were notified as required by administrative rule, or that the participant refused this notification.

More frequent monitoring of waiver participants' ISPs and health and safety may occur as the result of complaint investigations. Additional monitoring may also be conducted in instances when SLP providers receive repeat complaint investigation findings of non-compliance within a twelve month period. The findings do not have to be the same or related.

Administrative rule violations related to ISP implementation and the health and welfare of residents must be individually remediated and may be cited as findings of non-compliance by the SMA. The SLP provider is given a Response to On-Site Review Findings form which outlines the rule violations. The SLP provider must then develop and implement a plan of correction (POC) within 30 days of receipt of the findings. SMA staff performs an on-site follow-up review to ensure the POC has been implemented and has corrected the problem. If it has not, another 30 days is allowed and another follow-up review is conducted. If at this time the SLP provider still has not corrected the non-compliance, sanctions may be issued by the SMA, including termination of the Medicaid provider agreement. The same process applies for SLP providers in the dementia program.

For participants enrolled in an MCO, the Plan is also responsible for monitoring service plan implementation, including whether services and supports meet the participant's needs.

The Plans have a process to implement a method of monitoring its staff to include, but not be limited to conducting quarterly case file audits and quarterly reviews. These reviews verify that service plans are completed with each assessment or in between assessments if members' needs have changed and that services listed on the service plan address members' needs identified in the comprehensive assessment. 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 Plan has taken to resolve identified issues. The Plans will provide the SMA with 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 SMA selects a statistically valid sample for conducting onsite record reviews to verify compliance with federal assurances. The SMA uses a proportionate sampling methodology with a 95% confidence level and a 5% margin of error. The methodology will be adjusted when new MCOS are enrolled to ensure proportionate sampling across all MCOs.

**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:**

**Number/percent of waiver participants' and MCO waiver participants' service plans that address all of their assessed needs and personal goals. Numerator:** Number of waiver participants' and MCO waiver participants' service plans that address all of their assessed needs and personal goals. **Denominator:** Total number of waiver participants' and MCO waiver participants' service plans reviewed.

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<input type="text"/>
----------------------

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**##% of dementia program waiver participants' service plans that address all of their assessed needs and personal goals. Numerator: # of dementia program waiver participants' service plans that address all of their assessed needs and personal goals. Denominator: Total # of dementia program waiver participants'**

service plans reviewed.

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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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:**

**Number/percent of dementia program waiver participants who have a service plan completed within 7 days of their comprehensive assessment. Numerator: Number of dementia program waiver participants with service plans completed within 7 days of their comprehensive assessment. Denominator: Total number of dementia program waiver participant service plans reviewed.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input type="text"/> ^ v
--	--------------------------------

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/> ^ v	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/> ^ v

**Performance Measure:**

Number/percent of waiver participants who have service plans completed within 7 days of their comprehensive assessment. Numerator: Number of waiver participants with service plans completed within 7 days of their comprehensive assessment. Denominator: Total number of waiver participant service plans reviewed.

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/> ^ v	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/> ^ v
	<input checked="" type="checkbox"/> Continuously and	<input type="checkbox"/> Other

	Ongoing	Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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:**

Number/percent of dementia program waiver participant service plans updated following an annual assessment. Numerator: Number of dementia program waiver participant service plans updated following an annual assessment. Denominator: Total number of dementia program waiver participant service plans reviewed that required an annual assessment.

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

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):	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number/percent of dementia program waiver participant service plans updated following a significant change in condition. Numerator: Number of dementia program waiver participant service plans updated following a significant change in

**condition. Denominator: Total number of dementia program waiver participant service plans reviewed who experienced a significant change in condition.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

	Specify: <input type="text"/>
--	----------------------------------

**Performance Measure:**  
**Number/percent of waiver participant service plans updated following an annual assessment. Numerator: Number of waiver participant service plans updated following an annual assessment. Denominator: Total number of waiver participant service plans reviewed that require an annual assessment.**

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

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**Performance Measure:**

**Number/percent of waiver participant service plans updated following a significant change in condition. Numerator: Number of waiver participant service plans updated following a significant change in condition. Denominator: Total number of waiver participant service plans reviewed who experienced a significant change in condition.**

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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:**

**Number/percent of waiver participants with written documentation of services provided according to the service plan. Numerator: Number of waiver participants with written documentation of services provided according to the service plan. Denominator: Total number of waiver participant records reviewed.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify:	
<input type="checkbox"/> <b>Other</b> 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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify:	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify:

**Performance Measure:**

Number/percent of dementia program waiver participants with written documentation of services provided according to the service plan. Numerator: Number of dementia program waiver participants with written documentation of services provided according to the service plan. Denominator: Total number of dementia program waiver participant records reviewed.

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b>

		Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

Number/percent of waiver participants with signatures on their service plan which attests to their choice of waiver services instead of institutional care. Numerator: Number of waiver participants with signatures on their service plan attesting their choice of waiver services. Denominator: Total number of waiver participant service plans reviewed.

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Other  
Specify:

**Performance Measure:**

Number/percent of new waiver participants with a signed resident contract with the SLP provider attesting their choice of provider. Numerator: Number of new waiver participants with a signed resident contract with the SLP provider attesting their choice of provider. Denominator: Total number of new waiver participants reviewed.

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**Number/percent of dementia program waiver participants with signatures on their service plan which attests to their choice of waiver services instead of institutional care. Numerator: Number of dementia program waiver participants with signatures on their service plan attesting their choice of waiver services. Denomin: Total number of dementia program waiver participant service plans reviewed.**

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

<b>aggregation and analysis (check each that applies):</b>	<b>analysis(check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number/percent of dementia program waiver participants with a signed resident contract with the SLP provider attesting their choice of provider. Numerator: Number of new dementia program waiver participants with a signed resident contract with the SLP provider attesting their choice of provider. Denominator: Total number of new dementia program waiver participants reviewed.

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify: <input type="text"/>	
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**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 samples for the record reviews to verify participants' assessed needs and goals are included in the service plan will include two separate samples; one for all waiver participants and a second just for those enrolled in an MCO. The samples identified by the SMA for participants enrolled in an MCO for review by the EQRO will be proportionate among the Plans. These samples will be less than 100% review, but will have a 95% confidence level and a 5% margin of error. The random representative sample for all waiver participants used by SMA staff to review service plans will have a 95% confidence level and a +/-5% margin of error.

**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.

**Incomplete Service Plans:**

If a participant's service plan does not address all of his/her assessed needs, the service plan must be revised. This remediation is verified by SMA staff. EQRO staff verifies remediation for service plans created by an MCO for participants enrolled in managed care.

**Untimely Service Plans:**

When a participant does not have a current service plan, one must be developed and implemented. SMA staff verifies this remediation. For missing service plans and completed but untimely service plans, the SMA may issue findings of non-compliance. See the procedure outlined at the end of this section.

**Service Plans Following Annual Assessment:**

If a waiver participant's service plan is not updated following the required annual assessment, this must occur once identified. SMA staff verify this remediation.

**Significant Changes in Condition:**

If a waiver participant's service plan is not updated following a significant change in condition requiring new services, it would have to be updated once discovered. Additionally, the SLP provider would have to provide or arrange for any new services as the result of the change in condition. SMA staff verifies this remediation

occurs.

**Documentation of Services:**

If SMA staff cannot find evidence of services identified in the waiver participant's service plan being provided, the plan would have to be updated accurately to reflect the services that are needed. SMA staff verifies this remediation occurs and that the participant is receiving needed and preferred services.

**Signed Service Plan:**

When a waiver participant's signature, or their designated representative's, is not included on the service plan, the plan must be reviewed with the waiver participant. After the review, the waiver participant is given the choice of accepting the waiver services outlined by signing the service plan. SMA staff verifies the signature is in place.

**Signed Resident Contract:**

When a waiver participant's signature, or their designated representative's, is not on the resident contract, the contract must be reviewed with the participant. After the review, the participant is given the choice of accepting the provider for waiver services, which is indicated by signing the contract. SMA staff verifies the signature is in place.

In all cases of individual non-compliance outlined above, including in the dementia program, the SMA may issue findings of non-compliance to SLP providers for individual problems when discovered. The SLP provider is presented with a form outlining the areas of non-compliance. A plan of correction (POC) must be submitted to the SMA within fourteen days of receiving the findings. The POC must be implemented within 30 days. SMA staff performs an onsite follow-up review to determine if remediation has occurred. If non-compliance is still identified, the SLP provider receives another form outlining the current non-compliance areas and is given another 30 days to correct. Continued non-compliance during a second onsite follow-up review by SMA staff results in sanctions, including but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with relocation options, including transferring to another SLP provider. In the case of services not being provided, Medicaid reimbursement could be recovered.

**ii. Remediation Data Aggregation**

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify:  EQRO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:  <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**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**

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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**

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E-1: Overview (1 of 13)

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

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**Appendix E: Participant Direction of Services**

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E-1: Overview (2 of 13)

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

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**Appendix E: Participant Direction of Services**

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E-1: Overview (3 of 13)

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

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**Appendix E: Participant Direction of Services**

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E-1: Overview (4 of 13)

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

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**Appendix E: Participant Direction of Services**

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E-1: Overview (5 of 13)

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

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**Appendix E: Participant Direction of Services**

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E-1: Overview (6 of 13)

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (7 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (8 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (9 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (10 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (11 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (12 of 13)**

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

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**Appendix E: Participant Direction of Services**

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**E-1: Overview (13 of 13)**

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

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**Appendix E: Participant Direction of Services**

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

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

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**Appendix E: Participant Direction of Services**

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

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

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**Appendix E: Participant Direction of Services**

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

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

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## Appendix E: Participant Direction of Services

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

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

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## Appendix E: Participant Direction of Services

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

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

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## Appendix E: Participant Direction of Services

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

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

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## Appendix F: Participant Rights

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### Appendix F-1: Opportunity to Request a Fair Hearing

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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.

The State of Illinois assures that each person whose request for assistance is denied is provided an opportunity for a fair hearing. Applicants and/or clients have the right to appeal any action, such as a denial or termination of services or reductions in service level. Illinois assures an opportunity for a fair hearing under 42 CFR Part 431, Subpart E, to waiver participants and potential waiver participants who are not given the choice of SLP services as an alternative to nursing facility services. This can occur as a result of not being determined eligible for Supportive Living Program (SLP) waiver services or receiving a notice of involuntary discharge from a SLP provider.

Waiver participants or their designated representative are informed of the appeal process in writing at the time of the denial of services. Furthermore, resident contracts for SLP providers must contain information regarding the involuntary discharge process, including the participant's right to appeal (89 IL Admin. Code, Subpart B, Section 146.240(b)(5), "The resident contract shall include, but not be limited to the following: The conditions under which the resident contract may be terminated by either party"). All resident contracts must be approved by the SMA, which insures appeal information is included.

**Eligibility for SLP waiver services:**

Prior to admission, all potential waiver participants, including those in the dementia program, must undergo an initial level of care assessment known as the Determination of Need (DON). Potential participants must meet a minimum score required for enrollment in the State's Medicaid-funded long term care program (either institutional or home and community-based services waivers), including the SLP. If a potential participant disagrees with the preadmission screening results, he may submit a request for an appeal to the SMA. An appeal form and self-addressed postage paid envelope is provided to the potential participant by the SLP provider. The SMA is responsible for maintaining the appeal documents and also reviews appeals.

Level of Care Determinations (LOCD) are performed annually for each waiver participant, including those in the dementia program, by the SMA. If a participant is found to no longer meet the required minimum level of care, a case action notice form is issued by the SMA. This form contains the reason(s) why the participant is no longer eligible for the program.

Additionally, a notice of appeal form is supplied to the participant that contains a phone number for the SMA to request assistance with filing the appeal. The SMA is responsible for maintaining the case action notice form and also reviews appeals.

#### Additional assessments:

If a prospective resident or his/her representative disagrees with a mental health review completed by a qualified Department of Human Services (DHS) screening agent for the purpose of assessing persistent risks and needs to inform whether the person is appropriate for SLP placement, he/she may request an appeal through DHS. If the prospective resident or his/her representative does not agree with the response, the decision may be appealed to the SMA. Information regarding the appeal process is provided in writing to the prospective resident.

#### Involuntary Discharge From a SLP Provider:

SLP providers must provide written involuntary discharge notices to waiver participants (89 IL Admin. Code, Subpart B, Section 146.255 (b)), "The SLF shall provide a resident with a 30-day written notice of proposed involuntary discharge unless such a delay might jeopardize the health, safety, and well-being of the resident or others"). A 30-day notice is required, except in instances when participants are a danger to themselves or others, or when the participant's physical or mental health care needs require discharge sooner when health and safety are an issue (IL Admin. Code, Subpart B, Section 146.255 (b) and (e), "The 30-day notice required under subsection (b) of this Section shall not apply in either of the following instances; however, a notice and right to appeal information must still be provided when an immediate discharge is required: 1) When an emergency discharge is mandated by the resident's health care or mental health needs as documented in the resident record. The SLF may consult with the attending physician for additional support on the emergency discharge. 2) When the discharge is mandated to ensure the physical safety of the resident and other residents as documented in the resident record"). A 30-day written notice of discharge can be issued by a SLP provider when: a participant breaches the resident contract, the provider has had its certification terminated, suspended, or not renewed by the SMA, the provider cannot meet the participant's needs with the required support services or when a participant has received proper notice of failure to pay the SLP provider for room and board and/or services. In the instance of non-payment, the participant has the right to make full payment up to the date that the discharge is to be made and then shall have the right to remain at the SLP residence.

The notice of involuntary discharge form must be completed by the SLP provider and given to the participant. The form includes the reason(s) for discharge, information for filing an appeal and a phone number for the SMA to request assistance with filing the appeal (89 IL Admin. Code, Subpart B, Section 146.255(b)). The SLP provider is required to supply a self addressed, stamped envelope with the appeal form (89 IL Admin. Code, Subpart B, Section 146.255(b)(4), "A hearing request form together with a postage paid, preaddressed envelope to the Department"). If an appeal is filed, the discharge is stayed until the hearing decision is rendered. The rule states that the participant may remain at the SLP residence until the 10th day after the receipt of the SMA's hearing decision, unless the participant is a danger to himself or others. The SLP provider is responsible for maintaining the notice of involuntary discharge form and right to appeal information. The SMA is responsible for conducting the hearing.

The Illinois Long Term Care Ombudsman program can assist participants with filing an appeal for any denial or reduction in services.

The above requirements apply to participants in the dementia program and enrolled in an MCO as well.

## 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.

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## 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 SMA is responsible for operating the Supportive Living Program complaint system.

Each MCO is required to establish and maintain a procedure for reviewing grievances (any expression of dissatisfaction about any matter other than an action or provider violation of administrative rule requirements) registered by enrollees. All grievances are registered initially with the MCO and may later be appealed to the Department through the Fair Hearing process. Enrollees must exhaust the MCO's grievance process before requesting a Fair Hearing.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Complaints about Supportive Living Program (SLP) providers may be registered by anyone. Complaints are received from waiver participants, friends and family, SLP provider employees and State long term care ombudsman. Individuals may register a complaint anonymously. The SMA receives complaints directly via a toll free telephone number, e-mail, written correspondence and in-person during on-site visits by SMA staff. There is no timeline for registering complaints. Complaints investigated by the SMA must be relevant to waiver services and program requirements. Additionally, all complaints are kept confidential.

When the SMA receives a complaint involving a possible administrative rule violation, a SLP Complaint Referral Notice form is completed and forwarded to regional SMA staff. This form contains specifics about the complaint, including waiver participants and staff involved, the nature of the complaint and date(s) of incident(s). For confidentiality, participant and staff names are not identified on the form itself, but are provided to regional SMA staff on an attached key. SMA staff must begin an investigation within seven days of receipt of the complaint. If a complaint involves immediate participant health and safety issues, regional staff are directed to investigate sooner. SMA employees are also mandated reporters. This status requires them to report suspected abuse or neglect of participants to local law enforcement.

Complaint investigations are performed on-site at the SLP residence. Investigations may involve interviews with waiver participants and staff, review of participant and employee records, a tour of the building and observation of staff providing services. Substantiated administrative rule violations are reported in writing to the SLP provider. The SLP provider must develop and implement a plan of correction within 30 days of receipt of the findings. SMA staff performs an on-site follow up review to verify remediation has occurred and that the SLP provider is in compliance with administrative rules. Persistent non-compliance in making corrections results in sanctions, including, but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants in identifying possible relocation options, including transferring to another SLP residence.

State long term care ombudsman also receive a copy of the SLP Complaint Referral Notice. Ombudsman can choose to attend the on-site the review with SMA staff, and/or perform their own investigation.

Concerns regarding denial of Medicaid eligibility and involuntary discharges are not handled by the complaint investigation process. In both of these instances, waiver participants are provided an opportunity to file a request for a Fair Hearing. The Fair Hearing process and complaint system are separate and independent.

When a participant is issued a notice of involuntary discharge or a notice that they are no longer eligible for the SLP

waiver, a SMA designated appeal form is also provided to request a Fair Hearing. The appeal request form includes contact information for the SMA. SMA staff and long term care ombudsman are available to assist participants with completing the appeal request form and to answer any questions. Each SLP provider is also required to post SMA complaint hotline posters and LTC ombudsman posters on each floor in the building. Additionally, a copy of the SMA's Resident Rights brochure, which includes the toll-free complaint hotline number, must be provided to participants at the time of their initial and annual assessments.

The above also applies to participants in the dementia program and those enrolled in an MCO.

For participants enrolled in an MCO, applicable grievances shall be registered initially with the Plan and may later be appealed to the SMA. The Plan's procedures must (i) be submitted to the SMA in writing and approved in writing by the SMA; (ii) provide for prompt resolution and (iii) assure the participation of individuals with authority to require corrective action. The Plan must have a Grievance Committee for reviewing grievances registered by its enrollees, and enrollees must be represented on the Grievance Committee. At a minimum, the following elements must be included in the Grievance process:

- An informal system, available internally, to attempt to resolve all grievances;
- A formally structured grievance system that is compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 CFR Part 438 Subpart F to handle all grievances subject to the provisions of such sections of the Act and regulations (including, without limitation, procedures to ensure expedited decision making when an enrollee's health necessitates);
- 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 Patients Rights Act. All enrollees must be informed that such a process exists. Grievances at this stage must be in writing and sent to the Grievance Committee for review;
- The Grievance Committee must have at least one enrollee on the Committee. The SMA may require that one member of the Grievance Committee be a representative of the SMA;
- 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 SMA under its Fair Hearings system;
- A summary of all grievances heard by the Grievance Committee and by independent external reviewers and the responses and disposition of those matters must be submitted to the SMA quarterly; and
- An enrollee may appoint a guardian, caretaker relative, primary care provider, women's healthcare provider, or other physician treating the enrollee to represent the enrollee through 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.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*
- Yes. The State operates a Critical Event or Incident Reporting and Management Process** (complete Items b through e)
- No. This Appendix does not apply** (do not complete Items b through e)  
If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.
- 
- b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The 89 IL Admin. Code, Subpart B, Section 146.295 defines an emergency as an event as the result of a mechanical failure or a natural force such as water, wind, fire or loss of electrical power, that poses a threat to the safety and

welfare of residents, personnel and others present in the Supportive Living Program (SLP) residence. Additionally, 89 IL Admin. Code, Subpart B, Section 146.305(b) states the SLP provider manager or employee shall contact local law enforcement authorities immediately when suspected abuse, neglect or financial exploitation involving physical injury, sexual abuse, a crime or death occurs to a participant as the result of actions by a staff member, family member, visitor or another resident. All of these incidents must be reported to the SMA within 24 hours of occurrence (89 IL Admin. Code, Subpart B, 146.295(l), "Upon the occurrence of an emergency resulting from a mechanical failure or natural force requiring hospital service, police, fire department or coroner, the SLF manager or designee must provide a preliminary report to the Department by fax within 24 hours of the occurrence" and 146.305(e), "Upon the occurrence of suspect abuse, neglect or financial exploitation that results in contact with local law enforcement, the SLF manager or designee must provide a preliminary report to the Department by fax within 24 hours after the occurrence". When a participant is harmed during an emergency (as defined above), the SLP provider must inform the participant's physician and the designated representative (89 IL Admin. Code, Subpart B, Section 146.245(h), "The SLF manager or licensed nursing staff shall alert the resident, his or her physician and his or her designated representative when a change in a resident's mental or physical status is observed by staff. Except in life-threatening situations, such reporting shall be within 24 hours after the observation. Serious or life-threatening situations should be reported to the physician and the resident's designated representative immediately. The SLF staff shall be responsible for reporting only those changes that should be apparent to observers familiar with the conditions of older persons or persons with disabilities"). Except in life threatening situations, this notification must take place within 24-hours. Notification by phone is acceptable.

Reports for the incidents outlined above must identify the type of emergency, date(s) it occurred, any outside agencies involved, the names of participants involved, evacuation location(s), number of injuries or deaths, estimate of the extent of damage to the building, and the SLP provider's response to the emergency/incident. SMA staff reviews reports to ensure incidents were handled appropriately by SLP provider staff, that the appropriate agencies were contacted and to determine if any further review is required. Follow-up information, such as police reports, employee termination documentation or coroner reports are obtained as applicable.

Additionally, Illinois' Mandated Reporter Act (320 ILCS 20) requires healthcare workers, State long term care ombudsman, SLP staff and SMA staff to report suspected instances of abuse, neglect and financial exploitation to law enforcement authorities for further investigation. The SLP provider is expected to cooperate with any outside investigation conducted by law enforcement.

The above also applies to participants in the dementia program and those enrolled in an MCO.

For participants enrolled in an MCO, the Plans have processes and procedures in place to receive reports of critical incidents. The Plans comply with the Elder Abuse and Neglect Act (320 ILCS 20/1). The Plans have a formal process for reporting incidents that may indicate abuse, neglect or exploitation on an enrollee. The Plans must comply with the SMA's critical incident reporting requirement and notify the SMA of any critical incidents discovered, if this occurs prior to the SLP provider submitting a report to the Plan and SMA. If the Plan perceives an immediate threat to the participant's life or safety, the Plan will follow emergency procedures, which may include calling 911.

SLP providers are required to submit critical incident reports involving MCO enrollees to the Plans, as well as the SMA. All incidents will be reported to the compliance officer or designee and entered into the Plan's Critical incidents report database. If SMA staff perform an on-site review in response to the critical incident, a summary of the report will be shared with the Plans.

The Plans will provide participants, their family or representatives information about their rights and protections, including how they can safely report an event and receive the necessary intervention and support.

Also, the Plans will assure 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.

Supportive Living Providers (SLP) are required to include resident rights, as detailed in 89 IL Admin. Code, Subpart B, Section 146.250(e), in the resident contract (89 IL Admin. Code, Subpart B, Section 146.240(b)(7), "The resident contract shall include, but not be limited to, the following: A list of the resident rights as stated in Section 146.250"). Included in these rights are the right to be free from mental, emotional, social and physical abuse and neglect and exploitation. Another is the right to be treated at all times with courtesy, respect and full recognition of personal dignity and individuality. Every participant or his/her designated representative must review and sign the resident

contract prior or at the time of admission. The SMA reviews SLP provider resident contracts to ensure resident rights information is included. Additionally, the SMA requires SLP providers to supply all participants with a "Hotline Information and Residents Rights" brochure at the time of admission. This brochure lists all of the rights participants have in the SLP and also offers the toll-free complaint hotline phone number. This brochure has been created and is distributed to SLP providers by the SMA. Resident rights information must also be provided annually at the time of the participant's required assessment. Additionally, SLP providers must display poster of the SMA's toll-free complaint hotline.

The SMA requires SLP providers to ensure limited English speaking participants have meaningful and equal access to services, including notification of their rights (89 IL Admin. Code, Subpart B, Section 146.215(n), "The SLF shall ensure that limited English speaking residents have meaningful and equal access to benefits and services"). This requirement can be met by having printed materials available in Braille and languages other than English, hiring bilingual staff or interpreters, and providing information to participants' representatives.

Additionally, SLP providers must encourage families of participants with impairments that limit the participant's decision making ability to arrange to have a responsible party or guardian represent the person's interests (89 IL Admin. Code, Subpart B, Section 146.215(o), "The SLF shall encourage families of residents with impairments that limit the resident's decision-making ability to arrange to have a responsible party or guardian represent the resident's interests").

During annual onsite reviews, SMA staff conduct interviews with waiver participants. A portion of the interview determines if the participant is aware of his/her rights. If a participant is not familiar or does not remember his/her rights, SMA provide them with a copy of the Hotline Information and Resident Rights brochure.

The State Long Term Care Ombudsman Program also distributes printed participant rights information. Additionally, contact information for registering complaints to the ombudsman is also provided.

The above also applies to participants in the dementia program and those enrolled in an MCO.

For participants enrolled in an MCO, the Plan shall train all of the Plan's employees, affiliated providers, affiliates and subcontractors to recognize potential concerns related to abuse and neglect, and on their responsibility to report suspected or alleged abuse or neglect. The Plans' employees who in good faith report suspicious or alleged abuse or neglect shall not be subjected to any adverse action from the Plans, its affiliated providers, affiliates or subcontractors.

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

The SMA receives critical incident reports. Participant abuse and neglect, serious injuries that require medical intervention and/or result in hospitalization, criminal victimization, death (other than by natural causes), financial exploitation and other incidents or events that involve harm or risk of harm to a participant are reported by SLP providers to the SMA (89 IL Admin. Code, Subpart B, Section 146.295(1), "Upon the occurrence of an emergency resulting from a mechanical failure or natural force requiring hospital service, police, fire department or coroner, the SLF manager or designee must provide a preliminary report to the Department within 24 hours after the occurrence. This includes, but is not limited to, loss of electrical power in excess of an hour, physical injury suffered by residents during a mechanical failure or force of nature, evacuation of residents for any reason, and fire alarm activation that results in an on-site response by the local fire department. It does not include fire department response that is the result of resident cooking mishaps that only cause minimal smoke limited to a resident's apartment or false alarms, as determined by the local fire department" and 146.305(e), "Upon the occurrence of suspect abuse, neglect or financial exploitation that results in contact with local law enforcement, the SLF manager or designee must provide a preliminary report to the Department by fax within 24 hours after the occurrence. This includes, but is not limited to, suspected abuse of any nature, allegations of theft, elopement of residents or missing residents, and any crime that occurs on facility property". An incident report must be submitted to the SMA within 24 hours of the occurrence.

The SMA reviews incident reports and determines if further follow-up is required according to established procedures. All follow-up is conducted by the SMA. Follow-up may be determined to be necessary by the SMA if a SLP provider did not notify the appropriate entities, such as police, physician or the participant's emergency contact. A follow-up investigation is required in the case of a serious incident, such as a fire. On-site reviews are also conducted in response to extended utility outages to verify that participants are safe and their needs are being met. The SMA will also investigate if incidents occur repeatedly or show a pattern.

The need for a follow-up review for critical incidents is determined based on the severity of the incident and the impact on participants, particularly their health and safety. SMA procedure requires on-site follow-up for incident

reports impacting resident health and safety. Examples include extended power outages lasting more than 48 hours, physical damage to a SLP residence as the result of weather, fire or physical plant malfunction and also resident injury or death resulting from an emergency, such as a fire.

Regional SMA staff conduct the on-site review within the next working day of being notified by supervisory SMA staff, or sooner if instructed. The review process includes examination of the physical structure of the SLP residence, interviews with participants and staff, participant and staff record reviews and also outside reports related to the incident, such as police reports. A preliminary report is submitted the day of the on-site review to SMA supervisory staff so that participant health and safety can be confirmed. A formal written report must be submitted within two working days of the on-site review.

If the SLP provider is determined to be out of compliance with regulations, the SMA issues findings of non-compliance. The SLP provider is presented the findings in writing. A plan of correction must be submitted to the SMA within fourteen days of receiving the findings of non-compliance. The plan must be implemented within thirty days. SMA staff performs an on-site follow-up review to determine compliance and remediation. Persistent non-compliance in making corrections results in sanctions including, but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff would assist participants with relocation, including transfer to another SLP residence.

Additionally, if participants' current health or safety were threatened as the result of the SLP provider's response to the critical incident, the SMA would issue an immediate jeopardy. Immediate jeopardy results in SMA staff staying on-site at the SLP provider residence until the areas of non-compliance involving immediate health and safety have been abated. Immediate jeopardy also requires the SLP provider to submit and implement a plan of correction within ten days. SMA staff performs an on-site follow-up review to determine if remediation has occurred. If continued non-compliance exists, the SMA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff would assist waiver participants with relocation, including transferring to another SLP residence.

Critical incident reports are also tracked by the SMA. Information captured in the tracking report includes: participant names, SLP provider names, type of incident, timeliness of submission, provider response to the incident and the outcome.

Participants and their families are able to obtain information related to on-site reviews of critical incident reports by contacting the SMA in writing or by phone. A copy of the written report for the on-site follow-up review is available through a Freedom of Information Act (FOIA) request. Protected health information is redacted from FOIA responses as applicable. SMA legal staff reviews all requests from participants or families and FOIA responses to verify compliance with HIPAA.

The above applies to participants in the dementia program and those enrolled in an MCO.

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

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

The SMA is responsible for overseeing critical incident reports for the Supportive Living Program (SLP). All written incident reports submitted by SLP providers are entered into a tracking log report on an ongoing basis as they are received. The log captures information including: provider name, type of incident, participant names, provider response, timeliness of submission and outcomes.

The incident report log is reviewed on a continuous basis so that any issues such as timeliness, notification of local law enforcement or provider response are addressed. Patterns or trends identified for a particular provider or type of incident can be addressed in this way. Problems identified statewide or in a certain geographic area are responded to by issuing clarifications via a formal provider notice to all SLP providers and/or by offering provider training. Patterns and trends seen within a specific provider result in the SMA issuing findings of non-compliance and/or supplying technical assistance and clarifications to the provider. In the case of findings, an SLP provider would be required to develop and implement a plan of correction within thirty days of receipt of the findings. SMA staff performs an on-site follow-up review to verify remediation has occurred and to determine compliance with administrative rules.

The review of required critical incident reports is also done on an annual and ongoing basis during on-site annual certification reviews and complaint investigations. While on-site, SMA staff review participant and provider documentation to confirm that the SLP provider submitted critical incident reports as required. These procedures also apply to the dementia program and participants enrolled in an MCO.

In addition, for participants enrolled in a an MCO, the Plans maintain an internal reporting system for tracking the reporting and response to critical incidents and analysis of the event to determine whether individual or systemic changes are needed. Critical incident reporting will be included in the reporting requirements to the SMA. The SMA monitors both compliance of performance measures and timeliness of remediation for those waiver participants enrolled in an MCO.

## 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 SMA is responsible for identifying the use of restraints. Oversight activities occur during on-site reviews, including annual certification reviews, complaint investigations and technical assistance visits.

During annual on-site certification reviews, SMA staff reviews participant records and also interview and inspect the apartments of a representative sample of participants. Participants are asked if they have been informed and are aware of their rights. This includes the right to be free of restraints. Participants are also questioned about their satisfaction with the care they receive and if they know to whom they may register complaints. Additionally, during the apartment inspection process, SMA staff has the opportunity to see any physical restraints.

The use of restraints is reported to the SMA via the toll-free complaint hotline, e-mail or written correspondence. Anyone, including participants, their families and provider staff, can register a complaint. SMA staff must perform on-site investigations in response to complaints received.

SMA staff conduct scheduled and unscheduled visits for the purposes of monitoring and providing technical assistance to Supportive Living Program (SLP) providers. These visits offer another opportunity for SMA staff to detect the use of restraints. Furthermore, the State Long Term Care Ombudsman Program informs the SMA if staff became aware of or suspect the use of restraints by an SLP provider.

If an SLP provider was using restraints with participants, the SMA would issue a finding of non-compliance. The SLP provider has 30 days to develop and implement a plan of correction from the date written notification of the non-compliance is provided. SMA staff performs an on-site follow-up review to verify the use of restraints was no longer being practiced. If non-compliance persists after a second follow-up review, the SMA implements sanctions, up to and including suspending or terminating the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a participant's health or safety was threatened by the use of restraints, the SMA would issue a notice of immediate jeopardy. If a participant is at risk at the time of the on-site review, SMA staff remains at the SLP provider until the area of non-compliance associated with the immediate jeopardy has been abated. Immediate jeopardy also requires the SLP provider to submit and implement a plan of correction within ten days of receipt of the findings. SMA staff performs an on-site follow-up review to verify that remediation has occurred and that the SLP provider is in compliance with administrative rules. If continued problems exist, the SMA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

These procedures apply to the dementia program and participants enrolled in an MCO.

Additionally, the MCO can detect the use of restraints through face-to-face visits, routine contacts with participants and possibly through complaint or incident reporting. If the Plans identify or learn of the use of restraints, it is reported as a critical incident and reported to the investigation authorities as indicated. In this instance, the Plan will be responsible for overseeing the waiver participant and assuring their health, safety and welfare.

- The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.**
  - i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

## Appendix G: Participant Safeguards

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

**b. Use of Restrictive Interventions. (Select one):**

- The State does not permit or prohibits the use of restrictive interventions**

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

The SMA is responsible for identifying restrictive interventions. Oversight activities occur during on-site visits, including annual certification reviews, complaint investigations, scheduled technical assistance visits and unannounced monitoring visits.

During on-site annual certification reviews, SMA staff reviews participant records and also interviews a representative sample of participants. Participants are asked if they have been informed and are aware of their rights. They are also asked about their satisfaction with the care they receive and if they know to whom they may register complaints. Additionally, during the record review, SMA staff has the opportunity to identify the use of restrictive interventions.

The use of restrictive interventions is reported to the SMA via the toll-free complaint hotline, email or written correspondence. Anyone, including participants, their families and provider staff, can register a complaint. Furthermore, the State Long Term Care Ombudsman Program informs the SMA if staff became aware of or suspect the use of restrictive interventions by a SLP provider. SMA staff must perform on-site investigations in response to complaints received.

SMA staff conduct scheduled and unscheduled visits for the purposes of monitoring and providing technical assistance to Supportive Living Program (SLP) providers. These visits offer another opportunity for SMA staff to detect the use of restrictive interventions.

If an SLP provider was using restrictive interventions, the SMA would issue a finding of non-compliance. The SLP provider has 30 days to develop and implement a plan of correction from the date written notification of the non-compliance is issued. SMA staff performs an on-site follow-up review to verify the use of restrictive interventions is no longer being practiced. Follow-up reviews are unscheduled. If non-compliance persists after

a second follow-up review, the SMA would impose sanctions, up to and including suspending or terminating the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a participant's health or safety was threatened by the use of restrictive interventions, the SMA would issue a notice of immediate jeopardy. If a participant is at risk at the time of the on-site review, SMA staff remains at the SLP provider until the area of non-compliance associated with the immediate jeopardy has been abated. Immediate jeopardy also requires the SLP provider to submit and implement a plan of correction within ten days of receipt of the findings. SMA staff performs an on-site follow-up review to verify that remediation has occurred and that the SLP provider is in compliance with administrative rules. If non-compliance is identified, the SMA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

Dementia program participants' safety needs are met with a service intervention of alarmed, delayed exit doors. When the door's release bar is pushed, an alarm sounds. The door will open if the bar is pushed for several continuous seconds. Dementia participants have the freedom to move within the dementia care setting, including access to secured outdoor common space.

Participation in the dementia program is voluntary. The participant, his/her physician, family and dementia program staff collaborate to determine if the dementia program is a beneficial setting. The need for extra supervision is based on a participant's individual characteristics and needs for care and support. All dementia participants must have an elopement risk assessment completed prior to admission and quarterly thereafter by a registered nurse to determine if alarmed, delayed exit doors are a necessary safety intervention. If a participant is assessed to no longer require this intervention, SLP provider staff discusses a different community placement with the participant and his/her designated representative. SMA staff review elopement risk assessments during on-site certification reviews for all participants.

Dementia program participants are able to leave the dementia care setting at any time with staff, family or other designated individuals. SLP provider activities includes options both on-site and in the larger community. Dementia participants may also have visitors at any time. Visits by family and friends are encouraged and do not have to be prearranged with the SLP provider. SLP provider staff is available 24 hours per day to allow visitors access to the building.

SMA staff completes on-site annual certification reviews for the dementia program. SMA staff verifies that participants have been appropriately assessed for the needed safety intervention of alarmed, delayed exit doors. They also confirm assessments were timely, complete and accurate. Participant access to common areas is also verified. If program non-compliance is identified, the process outlined above for SLP providers is followed.

- **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 SMA is responsible for identifying the use of seclusion. Oversight activities occur during on-site reviews, including annual certification reviews, complaint investigations, scheduled technical assistance and unannounced monitoring visits.

During annual on-site certification reviews, SMA staff reviews participant records and also interview and inspect the apartments of a representative sample of participants. Participants are asked if they have been informed and are aware of their rights. Participants are also questioned about their satisfaction with the care they receive and if they know to whom they may register complaints. Additionally, during the apartment inspection process, SMA staff has the opportunity to verify the participant is not in seclusion.

The use of seclusion is reported to the SMA via the toll-free complaint hotline, e-mail or written correspondence. Anyone, including participants, their families and provider staff, can register a complaint. SMA staff must perform on-site investigations in response to complaints received.

SMA staff conducts scheduled and unscheduled visits for the purposes of monitoring and providing technical assistance to Supportive Living Program (SLP) providers. These visits offer another opportunity for SMA staff to detect the use of seclusion. Furthermore, the State Long Term Care Ombudsman Program informs the SMA if staff became aware of or suspect the use of seclusion by an SLP provider.

If an SLP provider was found to be using seclusion with participants, the SMA would issue a finding of non-compliance. The SLP provider has 30 days to develop and implement a plan of correction from the date written notification of the non-compliance is provided. SMA staff performs an on-site follow-up review to verify the use of seclusion was no longer being practiced. If non-compliance persists after a second follow-up review, the SMA issues a sanction, up to and including suspension or termination the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a participant's health or safety was threatened by the use of seclusion, the SMA would issue a notice of immediate jeopardy. If a participant is at risk at the time of the on-site review, SMA staff remains at the SLP provider until the area of non-compliance associated with the immediate jeopardy has been abated. Immediate jeopardy also requires the SLP provider to submit and implement a plan of correction within ten days of receipt of the findings. SMA staff performs an on-site follow-up review to verify that remediation has occurred and that the SLP provider is in compliance with administrative rules. If continued problems exist, the SMA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

These procedures apply to the dementia program and participants enrolled in an MCO.

Additionally, the MCO can detect the use of seclusion through face-to-face visits, routine contacts with participants and possibly through complaint or incident reporting. If the Plans identify or learn of the use of seclusion, it is reported as a critical incident and reported to the investigation authorities as indicated. In this instance, the Plan will be responsible for overseeing the waiver participant and assuring their health, safety and welfare.

**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.

Supportive Living Program (SLP) providers are responsible for ongoing monitoring of medication regimens for participants who choose to receive medication management services.

Information regarding participant medication orders is obtained at the time of the initial assessment, which is conducted within 24 hours of admission. The initial assessment should include a participant's medications, dosage, frequency and any assistance they require. This information is captured again during the comprehensive assessment completed within seven to fourteen days after admission. After the comprehensive assessment, medication regimens are reviewed and updated as needed after physician visits, hospitalizations or a change in a participant's condition. At a minimum, a participant's medication regimen must be assessed on a quarterly basis during required reviews. A licensed nurse is responsible for these reviews.

As part of the comprehensive assessment, a participant's ability to safely manage his/her own medication is examined. If a participant requires assistance, either in the form of medication set up, reminders, cuing for self-administration or administration, this is included in the service plan.

Additionally, a SMA form must be completed for medication errors identified by the SLP provider. SLP provider staff is responsible for completing this form, which includes a summary of the error, information regarding the notification of the participant's physician and a plan of correction. The same process for medication errors is required for dementia program participants and those enrolled in an MCO. For participants enrolled in an MCO, the SLP provider must notify the Plans of medication errors.

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

The SMA is responsible for monitoring medication management services provided to waiver participants by Supportive Living Program (SLP) providers. Records of waiver participants are reviewed extensively during on-site annual certification reviews. This includes examining comprehensive assessments, service plans, physician orders and medication management service records. SMA staff also observe the delivery of medication management services by SLP provider staff.

During the record review, SMA staff makes sure the participant's assessment corresponds with the service plan and the correct medication management service is identified. SMA staff also verifies that service plans are implemented and that participants receive services contained in the plan. Medication management service records are reviewed to verify required information is included, such as staff initials/signatures indicating the service was provided. Additionally, Medication Error Report forms are reviewed by SMA staff to verify they

were completed as required, physician notification occurred and a plan of correction to prevent errors in the future was included.

If SMA staff discovers medication errors and/or physician's orders are not followed in regards to medication management services, findings of non-compliance would be issued. The SLP provider is required to develop and implement a plan of correction within thirty days of receiving written notice of the findings. SMA staff performs an on-site follow-up review to verify remediation has occurred and the provider is in compliance with administrative rules. Continued non-compliance can result in sanctions, including, but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a participant's current health or safety were threatened as the result of a medication management services not being provided appropriately, the SMA would issue a notice of immediate jeopardy. If the participant is at-risk at the time of the on-site review, SMA staff remains at the SLP provider residence until the immediate jeopardy has been abated. Immediate jeopardy requires the SLP provider to develop and implement a plan of correction within ten days. SMA staff perform an on-site follow up review to determine that remediation has occurred and the provider is in compliance with administrative rules. If continued non-compliance exists, the SMA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement is terminated, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

The same procedures apply for the dementia program and participants enrolled in an MCO.

## Appendix G: Participant Safeguards

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

#### c. Medication Administration by Waiver Providers

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

- Not applicable. *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
- ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Supportive Living Program (SLP) providers are required to provide medication management services. Depending upon participant needs and preferences, SLP staff offers a spectrum of medication management services. Among these are: medication set-up, verbal reminders, assistance with self-administration and medication administration (89 IL Admin. Code, Subpart B, Section 146.230(b)(2-3)), "When a resident is unable to administer his or her own medications, a licensed nurse shall administer the medications", "Nursing services shall include medication set-up (such as preparing weekly pill caddies with that week's medication" and (d), "medication Administration, Oversight and Assistance in Self-Administration").

As provided in the Nurse Practice Act (225 ILCS 65], only licensed nursing staff (registered or licensed practical nurse) may set-up medications or administer medications. Certified nursing assistants (CNA) are allowed to perform verbal medication reminders, hand participants their set-up medication from where it is stored and open medication containers.

SLP provider staff must document medication management services including the date, time, and staff signature/initials.

##### 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:

All medications errors that occur for participants receiving medication management services from the Supportive Living Program (SLP) provider are required to be recorded on a Medication Error Report form. Medication errors that result in adverse reaction requiring hospitalization must be reported on the required form to the SMA within 24 hours. All other errors are recorded on the Medication Error Report form and made available to the SMA at its request. The form includes the name of the participant involved, the medication(s) and the type of error (i.e; time, dosage, etc.) and any adverse reaction observed. Additionally, the SLP provider must document that the physician and emergency contact were notified and include information regarding any instructions provided by the physician. Finally, the SLP provider must implement a plan of correction to prevent additional errors. These requirements also apply to the dementia program and participants enrolled in an MCO.

For participants enrolled in an MCO, the Plans have processes for receiving medication error reports. The Plans also have processes for managing medication errors, including case management processes as well as reporting processes. Medication errors are forwarded to Medical Directors for review and follow up. These instances are also forwarded to the routine Peer Review Committee in MCOS for review, investigation and recommendations for follow-up. The procedures include processes for ensuring participant safety.

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

Medication errors must be reported for participants who receive medication management services from the Supportive Living Program provider. These services include medication set-up, verbal reminders and administration. The SMA defines a medication error as the wrong medication, wrong dose, wrong time (in excess of one hour in most instances), wrong route or a missed medication. These reports must be made available upon the SMA's request.

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

Medication errors that result in adverse reactions requiring hospitalization must be reported in writing to the SMA within 24 hours on the Medication Error Report form. The form includes the name of the participant involved, the medication(s) and the type of error (i.e, time, dosage, etc.) and any adverse reaction observed. Additionally, the Supportive Living Program (SLP) provider must document that the physician and emergency contact were notified and include information regarding any instructions provided by the physician. Finally, the SLP provider must provide a plan of correction to prevent future errors.

- 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.

SMA staff monitors medication management services received by waiver participants annually during on-site certification reviews and also continuously and ongoing in response to complaints. During on-site reviews, the records of participants are reviewed, including documentation of medication management services and physician's orders, as well as Medication Error Reports. SMA staff verifies participants are receiving the medication services they need based on their comprehensive assessment, that physician orders are followed and that medication management services are documented as required. Medication Error Reports are reviewed for completeness and accuracy. SMA staff also verifies that medication administration is performed only by licensed nurses. Participants and Supportive Living Program (SLP) provider staff are also interviewed. SMA staff can observe the delivery of medication management services, if necessary.

**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 instances of 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:**

**Number/percent of waiver participants whose funds are managed by the SLP provider according to program regulations. Numerator: Number of waiver participants whose funds are managed by the SLP provider according to program regulations. Denominator: Total number of waiver participants reviewed who received management of funds by the SLP provider.**

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

#/% of dementia program waiver participants whose funds are managed by the SLP provider according to program regulations. Numerator: Number of dementia program waiver participants whose funds are managed by the SLP provider according to program regulations. Denominator: Total number of dementia program waiver participants reviewed who received management of funds by the SLP provider.

**Data Source (Select one):**

Record reviews, on-site  
If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval =

<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Number/percent of interviewed waiver participants who report their rights, choices and preferences are respected. Numerator: Number of interviewed waiver participants who report their rights, choices and preferences are respected. Denominator: Total number of waiver participants interviewed.

**Data Source (Select one):**

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

#/% of waiver participants' instances of alleged abuse, neglect, exploitation other crimes appropriately reported to the SMA, MCO and local law enforcement. N: # of waiver participants' instances of alleged a/n/e and other crimes approp. reported to the SMA, MCO and local law enforcement. D: Total # of waiver partic. with instances of alleged abuse, neglect, exploitation and other crimes.

Data Source (Select one):  
Critical events and incident reports  
If 'Other' is selected, specify:

Responsible Party for	Frequency of data	Sampling Approach
-----------------------	-------------------	-------------------

data collection/generation (check each that applies):	collection/generation (check each that applies):	(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
<input checked="" type="checkbox"/> Continuously and Ongoing		<input type="checkbox"/> Other Specify: <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>		

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
<input checked="" type="checkbox"/> Continuously and Ongoing	
<input type="checkbox"/> Other Specify: <input type="text"/>	

**Performance Measure:**

Number/percent of interviewed dementia program waiver participants who report their rights, choices and preferences are respected. Numerator: Number of

interviewed dementia program waiver participants who report their rights, choices and preferences are respected. Denominator: Total number of dementia program waiver participants interviewed.

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

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

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>
--	--

**Performance Measure:**

**#/% of dementia prog. partic.s' instances of alleged abuse, neglect, exploitation and other crimes approp. reported to the SMA, MCO and local law enforc. N:# of dementia prog. partic.s' instances of alleged a/n/e and other crimes approp. reported to the SMA, MCO, and local law enforc. D: Total # of dementia prog. partic. with alleged abuse, neglect, exploitation and other crimes.**

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample</b> Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**Number/percent of participant records reviewed where the participant received information about how and to whom to report A/N/E at the time of assessment.**  
**Num:** Number of participant records reviewed where the participant received information about how and to whom to report A/N/E at the time of assessment.  
**Denom:** Total number of participant records reviewed.

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

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

**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):
<input type="checkbox"/>	<input type="checkbox"/>

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**Performance Measure:**

**#/% of dementia program participant records reviewed where the participant received information about how and to whom to report A/N/E at the time of assessment. Num: Number of dementia program participant records reviewed where the participant received information about how and to whom to report A/N/E at the time of assessment. Denom: Total number of dementia program participant records reviewed.**

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

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number/percent of participant deaths as a result of substantiated case of A/N/E

where appropriate follow up actions were implemented by the SMA. Numerator: Number of participant deaths as a result of a substantiated case of A/N/E where appropriate follow-up actions were implemented by the SMA. Denominator: Total number of participant deaths as a result of a substantiated case of A/N/E.

Data Source (Select one):  
 Critical events and incident reports  
 If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/> ^ <input type="text"/> v
<input type="checkbox"/> Other Specify: <input type="text"/> ^ <input type="text"/> v	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/> ^ <input type="text"/> v
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/> ^ <input type="text"/> v
	<input type="checkbox"/> Other Specify: <input type="text"/> ^ <input type="text"/> v	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/> ^ <input type="text"/> v	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing

Other  
Specify:

**Performance Measure:**

**#/% of dementia prog. participant (partic.) deaths as a result of substantiated case of A/N/E where appropriate follow up actions were implemented by the SMA.**

**Num: # of dementia prog. partic. deaths as a result of a substantiated case of A/N/E where appropriate follow-up actions were implemented by the SMA. Den:**

**Total # of dementia prog. partic. deaths as a result of a substantiated case of A/N/E**

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Number/percent of incident reports requiring additional review by the SMA completed within the required timeframes as described in the approved waiver. Numerator: Number of incident reports requiring additional review that were completed by the SMA within the required timeframes. Denominator: Total number of incident reports that required additional review.**

**Data Source (Select one):**

**Operating agency performance monitoring**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Number/percent of substantiated cases of A/N/E where the SLP provider implemented a plan of correction and was determined to be in compliance by the SMA. Numerator: Number of substantiated cases of A/N/E where the SLP provider implemented a plan of correction and was determined to be in compliance by the SMA. Denominator: Total number of substantiated cases of A/N/E.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**SMA on-site monitoring review of SLP provider.**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input checked="" type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample Confidence</b>

		Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**Performance Measures**

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

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

**Performance Measure:**

**Number/percent of waiver participants who are free from seclusion or restraints.**

**Numerator:** Number of waiver participants who are free from seclusion or restraints. **Denominator:** Total number of waiver participants reviewed.

**Data Source (Select one):**

**On-site observations, interviews, monitoring**

If 'Other' is selected, specify:

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

	Specify: <input type="text"/>
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**Performance Measure:**

Number/percent of dementia program waiver participants who had an elopement risk assessment completed according to program requirements. Numerator: Number of dementia program waiver participants who had an elopement risk assessment completed according to program requirements. Denominator: Total number of dementia program waiver participants reviewed.

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number/percent of dementia program waiver participants who are free from seclusion or restraints. Numerator: Number of dementia program waiver participants who are free from seclusion or restraints. Denominator: Total number of dementia program waiver participants reviewed.

**Data Source (Select one):**

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

<i>that applies):</i>	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

**#/% of dementia partic. referred to another setting when the elopement risk assess. no longer showed a need for an alarmed delayed exit door intervention. Num: # of dementia partic. referred to another setting when the elopement risk assess. no longer showed a need for an alarmed delayed exit door intervention. Denominator: Total # of dementia partic. requiring referral to another setting.**

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

	<input type="text"/> ^ v	
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**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/> ^ v	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/> ^ v

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

**Performance Measures**

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

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

**Performance Measure:**

Number/percent of medication errors documented and reported to the SMA.  
 Numerator: Number of medication error reports documented and reported to the SMA. Denominator: Total number of incidents of medication errors requiring documentation and reporting to the SMA.

Data Source (Select one):

Other

If 'Other' is selected, specify:

**Medication Error 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100%

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<b>Review</b> <input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number/percent of waiver participants who receive well-being checks in accordance with program rules. Numerator: Number of waiver participants receiving well-being checks in accordance with program rules. Denominator: Total number of waiver participants reviewed.

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

<b>Responsible Party for data</b>	<b>Frequency of data collection/generation</b>	<b>Sampling Approach (check each that applies):</b>
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<b>collection/generation</b> (check each that applies):	<i>(check each that applies):</i>	
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input checked="" type="checkbox"/> <b>Representative Sample</b> Confidence Interval = 95%
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

Number/percent of waiver participants who have working emergency call systems in their apartments. Numerator: Number of waiver participants with working emergency call systems in their apartment. Denominator: Total number of waiver participants reviewed.

**Data Source (Select one):**  
**On-site observations, interviews, monitoring**  
 If 'Other' is selected, specify:

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number/percent of medication errors for dementia program waiver participants documented and reported to the SMA. Numerator: Number of medication error reports for dementia program waiver participants documented and reported to the SMA. Denominator: Total number of incidents of medication errors requiring documentation and reporting to the SMA.

Data Source (Select one):

Other

If 'Other' is selected, specify:

**Medication Error 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually

<input checked="" type="checkbox"/> Continuously and Ongoing
<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**

Number/percent of dementia program waiver participants who received well-being checks in accordance with program rules. Numerator: Number of dementia program waiver participants receiving well-being checks in accordance with program rules. Denominator: Total number of dementia program waiver participants reviewed.

**Data Source (Select one):**

Record reviews, on-site

If 'Other' is selected, specify:

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

**Performance Measure:**  
 Number/percent of dementia program waiver participants with working emergency call systems in their apartments. Numerator: Number of dementia program waiver participants with working emergency call systems in their apartment. Denominator: Total number of dementia program waiver participants reviewed.

**Data Source (Select one):**  
 On-site observations, interviews, monitoring  
 If 'Other' is selected, specify:

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

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

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

**b. Methods for Remediation/Fixing Individual Problems**

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

**Incident Reporting:**

If a Supportive Living Program (SLP) provider did not report alleged abuse, neglect, exploitation or another crime against a waiver participant to the SMA and local law enforcement, it would be required to be submitted at the time this was discovered by the SMA. SMA staff reviews the required Preliminary Incident Report for completeness and accuracy to confirm remediation. In a case of alleged participant abuse, neglect or exploitation, the SMA would confirm local law enforcement had been notified. If a participant's safety was a concern at the time the allegation of abuse, neglect or exploitation was discovered, the SMA would review what steps the SLP provider had taken to keep the resident safe, such a placing an accused employee on administrative leave pending an investigation, and determine if further steps needed to be taken. SMA staff could also assist the participant with identifying temporary or permanent relocation options as well.

The SMA also tracks incidents by type, SLP provider and participant to monitor for patterns.

**SMA Review of Incident Reports:**

If SMA staff was found to be late with conducting on-site reviews related to incident reports or submitting summaries as required, the investigation/report would have to be completed immediately. Staff would also receive a reminder clarification regarding agency procedures for follow-up of incident reports. Continued non-compliance could result in administrative personnel action.

**Participant Rights/Choices:**

If a participant alleged his/her rights or choices were not being respected, SMA staff could investigate further. This could include reviewing the participant's record, interview of other participants, SLP provider staff interviews, and the review of provider policies. If the SMA discovered resident rights were not respected, findings of non-compliance could be issued (see below).

**Medication Error Reports:**

If it was discovered a Medication Error Report requiring submission to the SMA had not been sent, the SLP provider would need to complete a report (if not done previously) and send it immediately. SMA staff would

review the report form for completeness and accuracy to verify remediation. Findings of non-compliance could be issued (see below).

**Well-being Checks:**

If it was discovered a waiver participant did not have required well-being checks completed, the SMA could issue findings of not-compliance (see below). If checks had not been completed at all, SMA staff would remain on-site until the SLP provider remediated the non-compliance.

**Emergency Call Systems:**

If an emergency call system was not functioning in a waiver participant's apartment, the SLP provider would have to repair the system immediately or supply an alternative way for the participant to signal for help until the system was repaired. The SMA would have to approve the alternative alert. SMA staff would verify the system was repaired to document remediation. Findings of non-compliance could be issued (see below).

**Freedom from Restraints and Seclusion:**

If a participant was found in restraints or seclusion, or SMA learned a participant had been restraints or seclusion, the SLP provider would have to discontinue this practice immediately. SMA staff would verify the participant was not in restraints or seclusion in order to document remediation. Findings of non-compliance could be issued (see below). The SMA could also issue a notice of immediate jeopardy, as outlined in Appendix G.

**Management of Resident Funds:**

If a participant's funds were found not be managed by the SLP provider in accordance with regulations, SMA staff would instruct the SLP provider to correct this issue. SMA staff would confirm remediation had occurred. Findings of non-compliance could be issued (see below). If it was suspected the SLP provider was intentionally mismanaging participants' funds, the SMA's Office of Inspector General (OIG) would be notified to investigate further. Depending on the situation, the Illinois State Police could become involved at the request of the OIG.

**Elopement Risk Assessment (dementia program ONLY):**

If an elopement risk assessment had not been completed for a dementia program waiver participant, one would need to be done immediately. SMA staff would verify the completion of the assessment. If SLP provider staff did not refer a dementia program waiver participant to another community setting when their elopement risk assessment no longer indicated a need for an alarmed delayed exit door intervention, this referral would be required to be made immediately. SMA staff would perform follow-up to verify the referral information had been provided to the dementia program participant or his/her designated representative. Findings of non-compliance could be issued (see below).

In all cases of non-compliance with program rules outlined above, the SMA could issue findings of non-compliance for individual problems when discovered, including for the dementia program and for participants enrolled with an MCO. The SLP provider is presented with a form outlining the areas of non-compliance. A plan of correction must be submitted to the SMA within fourteen days of receipt of the form and must be implemented within 30 days. SMA staff performs an on-site follow-up review to verify remediation has occurred and to verify compliance. If non-compliance is still identified, the SLP provider receives another form outlining the non-compliance areas and is given another 30 days to correct. Continued non-compliance during a second on-site follow-up review by SMA staff results in sanctions, including but not limited to mandatory in-servicing of staff or termination of the Medicaid provider agreement. If a Medicaid provider agreement was terminated, SMA staff would assist waiver participants with relocation, including transferring to another SLP provider.

**ii. Remediation Data Aggregation**

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

Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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 SMA is responsible for the overall development and implementation of the Quality Improvement Strategy (QIS) for the Supportive Living Program (SLP) waiver. SMA staff performs on-site reviews continuously and ongoing to determine if requirements of the program are being met and that remediation occurs when necessary. Required reports are submitted by SLP providers continuously and ongoing. Data related to discovery of non-compliance and remediation is aggregated annually and reviewed by the SMA and Quality Workgroup. This can occur more frequently if it is suspected there is a significant issue of non-compliance with regulations.

A Quality Workgroup assembled by the SMA assists with the QIS development, processes, implementation and monitoring. The Workgroup is a collaboration of SMA staff, SLP providers, trade association staff, state agency staff involved with other HCBS waivers and long term care ombudsman. Members review QIS data and reports compiled by SMA staff in order to respond to patterns and trends that identify a need for system improvements, as well as monitoring ongoing quality improvement. The Quality Workgroup meets at least annually. Assurance Teams comprised of a smaller number of Workgroup members may be assembled to focus on patterns/trends of non-compliance for a specific assurance or performance measure. This would include developing a proposed QIS for review and approval by the Workgroup. Assurance team members can meet more frequently, as assignments require. Team members draft proposed system improvement recommendations, including performance measures, acceptable remediation, data sources and how improvement will be measured. These proposals are then presented to the Quality Workgroup to establish priority and final approval. SMA staff is responsible for follow-up at subsequent meetings to make sure action items identified and assigned at a previous meeting are addressed.

The QIS process begins with SMA staff compiling discovery and remediation information from annual certification reviews, critical incident reports, medication error reports and other sources identified in the approved waiver. This data is assembled into an individual report. Information in the report includes the numerator and denominator of the performance measure, data sources and any identified patterns or trends for a particular geographic area or provider group. This information is shared with Quality Workgroup members.

Performance measures with less than 86% compliance are identified as areas that require system improvement. Identified system improvement areas are then prioritized by Workgroup members based on severity, impact on waiver participant health and safety, frequency and geographic distribution of occurrences. Once prioritization is established, performance measures requiring system improvement are delegated to the appropriate Assurance Team. Members then begin developing interventions for possible system design changes. Data sources and options for measuring each system design change are also identified so that continuous quality improvement can be tracked.

Examples of interventions for system design changes could include:

- Program administrative rule changes
- Program policy and procedure changes
- Written clarification for SLP providers and/or SMA staff
- Resource tools for SLP providers and/or SMA staff
- Formal training
- Standardized forms

For managed care services, the SMA and External Quality Review Organization (EQRO) meet with MCOs on a quarterly basis to review data collected from on-site reviews. Reports compiled by the EQRO are provided to the SMA for review prior to the quarterly meeting. Annual reports are produced that identify trends based on the representative sample and/or 100% review of the data. Data will be reported by individual performance measures. Data to be reported will include level of compliance and timeliness of remediation based on immediate, 30, 60 and 90 day increments and any outstanding remediation.

During quarterly meetings, the SMA, EQRO and MCOs will discuss trends based on scope, severity, changes and patterns of compliance by reviewing both the level of compliance with the performance measures and remediation activities conducted by the MCOs. Identified trends will be discussed and analyzed regarding cause, contributing factors and opportunities for system improvements. Systems improvement will be prioritized based on factors such as: the impact on the health and welfare of waiver participants, legislative considerations and fiscal considerations. The MCOs will maintain a separate quality management system and improvident logs. Recommendations for system improvement will be added to the logs for tracking purposes. The MCOs will document the systems improvement implementation activities on its respective log. The SMA will assure 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 <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Other Specify: More frequently as required for monitoring of system changes.

**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 performance system design changes are monitored by the SMA through the collection and analysis of new performance measure data, as well as the comparison of previous data and patterns and trends. Once the need for a system change is identified by the Quality Workgroup, the Workgroup or the Assurance Team may develop a proposed system change(s), recommend data source(s), samples size(s) and measure(s) for tracking outcome(s). The proposed processes above may be outlined by the Workgroup, or an Assurance Team and presented to the Quality Workgroup. The Quality Workgroup discusses and determines the final changes(s) to be implemented, which data source(s) will be used and how improvement will be measured.

Once the data source is identified, it is assigned to a database tracking system to capture information from on-site annual reviews, or other designated sources. SMA staff is responsible for the collection of this data and entering it into the database. Any required changes to Medicaid agency policy and procedures, review tools or standardized forms are made and distributed to the appropriate parties. SMA staff will develop reports specific

to the system changes and related performance measures so that outcomes may be analyzed by the Quality Workgroup as a whole. Outcomes for system changes will be tracked for a minimum of one year. The Assurance Team will provide the Quality Workgroup with a summary of the performance of the system changes based on the outcomes. The Team will make recommendations as necessary for any revision to the system changes and explain why they are necessary. The Quality Workgroup will discuss and any approved revision to the system changes will be implemented, as outlined in the process above. This process will be repeated until such time as the system change has proved to be an effective quality improvement strategy (QIS). A system change will continue to be monitored for at least one additional year after it is deemed an effective QIS strategy to ensure continued quality improvement is demonstrated. The Quality Workgroup may also choose to designate the system change as a permanent part of the continuous quality improvement process.

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

The Quality Workgroup meets annually to review and evaluate the quality improvement strategy (QIS), including any in-process system changes. Reports containing data individualized for specific performance measures are developed by the SMA and distributed to Workgroup members. Patterns and trends, areas requiring system changes and any areas currently undergoing improvement are discussed. Additionally, at the request of an Assurance Team, the SMA can compile data reports for performance measures at any time, if the members are interested in reviewing system change outcomes more frequently.

The overall QIS is evaluated by the Quality Workgroup members at least annually. This includes evaluating current monitoring practices to ensure the information being gathered is the best data source for the performance measure, if the sample size is appropriate and also if SMA staff is interpreting the review process appropriately. Additionally, the Workgroup will review the priority ranking of system changes to verify that all areas impacting participant health and safety are being addressed.

## **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).

Supportive Living Program (SLP) providers rates are set by the SMA. A flat rate is paid for all services provided each day a Medicaid participant resides in a SLP provider building. Historically SLP provider fee-for-service payments have been generated by the SMA based upon participant data entered into the SMA's long term care database by staff of the Department of Human Services (DHS) and SLP providers. Information regarding participant admission, third party liability coverage, income changes and patient credit updates, discharge and death are communicated electronically by providers to DHS staff. DHS staff enters participant admissions, income and patient liability changes into the SMA's long term care database. Provider submissions regarding discharge or death go live into the long term care database and do not require review and entry by DHS staff. This process is effective for services provided through November 30, 2016.

Effective for services provided December 1, 2016 and after, SLP providers submit electronic claims each month to the SMA for Medicaid participants via the Department's Internet Electronic Claim system. Providers follow the UB04 and 837I Implementation guidelines to submit claims. Claim information includes the dates a participant is in the SLP building, temporary absence days and third party liability coverage. Claims are verified with information in the long term care database to ensure payment is made for Medicaid eligible participants who have been admitted to a SLP provider building, per review and approval by DHS staff. This review also ensures the correct daily reimbursement rate is paid.

SLP providers are also paid by Managed Care Organizations (MCO) with which the SMA contracts. The MCOs, through the Integrated Care Program (ICP), Medicare Medicaid Alignment Initiative (MMAI), Long Term Service and Supports (LTSS) and the Family Health Program (FHP) receive monthly capitated payments from the SMA and are responsible for managing and paying for the care of specific participants. The SLP providers bill the MCOs on a monthly basis and receive their payments directly from the MCO. The MCOs are required to have an internal process to validate payments to SLP providers, including a claims processing system verifying an individual's eligibility for SLP services. In addition, MCOs are required to submit their paid claims to the SMA as encounter data that is processed

through the SMA's MMIS to verify that payments were paid appropriately to Medicaid eligible providers for eligible participants.

A SLP provider representative must sign a remittance advice that accompanies each payment voucher to verify that the provider accepts the payment amount is correct. The remittance advice and the signature certification documents must be kept on file by the SLP provider for three years. In addition, SLP providers are required to submit cost report information on an annual basis to the SMA. The SMA's Bureau of Health Finance audits the cost reports and maintains the historical cost information.

The SMA's Office of Inspector General (OIG) has statutory authority to oversee the integrity of the Illinois Medicaid program in order to prevent, detect and eliminate fraud, waste and abuse. Pursuant to this authority, the OIG performs pre-payment and post-payment audits of SLP providers to ensure that appropriate payments are made for services rendered and to prevent and recover overpayments. The scope of the review for SLP providers includes but is not exclusive to: room and board ledgers, required SMA transactions related to payment generation, disbursement of participant personal allowance, temporary absences and participant cost of care received by the SLP provider. Additional areas of review include missing or insufficient medical records and signatures, as well as reviews of medical necessity of services billed.

All services for which charges are made to the SMA are subject to audit. During a review audit, the provider must furnish to the SMA's OIG or to its authorized representative, pertinent information regarding claims for payment. Should an audit reveal that incorrect payments were made, or that provider's records do not support the payments that were made, or should the provider fail to furnish records to support payments that were made, the provider is required to make restitution.

The SMA's OIG conducts both desk audits and field audits of SLP providers. Desk audits employ algorithms that analyze specific program billing reimbursement data that can be automatically validated. Claim data elements and established law and policy are used to determine if an overpayment was made. The overpayment amounts are verified through analytical methods. Field audits employ algorithms that analyze data that cannot be automatically validated, thus requiring a manual review of medical and other documentation.

The SMA's procedure for auditing providers can involve the use of sampling and extrapolation. Under such a procedure, the SMA selects a statistically valid sample of services for which the provider received payment for the audit period in question and audits the provider's records for those services. All incorrect payments determined by an audit of the services in the sample are then totaled and extrapolated to the entire universe of services for which the provider has been paid during the audit period. The provider is required to pay the SMA the entire extrapolated amount of incorrect payments calculated under this procedure after Final notice and/or an opportunity for hearing.

The SMA's OIG has the legal authority to perform audits on Medicaid providers during the course while the Medicaid provider is an active provider during the audit review period. The OIG has the legal authority to perform an audit on dates of service six years prior to when the audit is being commenced. A Medicaid audit can commence at any time although once a provider is audited, it is generally 1-2 years before a provider can be subject to an additional audit for the same audit reasons. The determination of the frequency of OIG audits depends upon many different factors, such as internal and external referrals and prioritization of audits.

The audit period depends upon the type of audit being performed. Audits are based upon dates of service and the OIG has the legal authority via Public Act 97-0689 to go back six years prior to when the audit is being commenced. For a sample/extrapolation audit, the audit period typically has 3 years of services reviewed. During a 100% audit, the audit period is typically 2 years of services. The type of audit (sample/extrapolated vs. 100%) is dependent upon the number of services billed and paid for by the SMA during the course of a three year time frame and is also dependent upon a referral reason for the audit.

MCOs also conduct post-payment plans of care and financial reviews. Additionally, the MCOs complete call-in checks for some waiver services to verify a provider was supplying services 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 Assurance:**

*The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

**i. Sub-Assurances:**

- a. *Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

**Performance Measures**

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

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

**Performance Measure:**

**Number/percent of payments made by the SMA for individuals enrolled in the Medicaid waiver. Numerator: Number of payments made by the SMA to waiver providers and MCOs for individuals enrolled in the Medicaid waiver.**

**Denominator: Total number of waiver provider and MCO payment records reviewed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

MMIS

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

	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	
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**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

- b. *Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.*

**Performance Measures**

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

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

**Performance Measure:**

**Number/percent of payments made for waiver services using the correct reimbursement rate. Numerator: Number of SMA and MCO payments using the correct rate. Denominator: Total number of SMA and MCO payments reviewed.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**MMIS**

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 95%
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = +/-5
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

	<input type="text"/>	
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**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- 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 SMA monitors compliance of performance measures and timeliness of remediation for those waiver participants (partic.) enrolled in a MCO. Partic. in MCOs are included in the representative(rep.) sampling. This review will include encounter claims submitted by MCOs. A random sample of MCO enrollees is reviewed.

Monitoring of the use of the correct reimbursement rate requires review of claims data and encounter data pulled from MMIS. Claims are priced by procedure code. The SMA will determine if the correct rate was used. The State's Auditor General currently contracts with KPMG to conduct the audit applicable to the Single Audit Act.

Personal care services (svcs.) are part of the waiver svc. package. Payment to SLP providers (prov.) is a flat daily rate regardless of the type or amount of svcs. requested and received by the partic. The type and frequency of svcs. is included in the partic.'s service plan.

During annual on-site certification reviews at each SLP prov., the SMA completes a record review for each new waiver partic. and a random, rep. sample of continuous waiver partic. This includes a thorough review of the partic.'s assess., plan of care, MD orders, nursing notes and medication assist. documen. A random, rep. sample of partic. are also interviewed. This verifies staff of the SLP prov. is supplying svcs. to eligible partic. with the frequency, amount and duration specified in the plan of care. Additionally, MMIS does not allow payment reimbursement for people who have not been determined to be eligible for the waiver. The SMA's OIG also completes post payment reviews.

The SMA also completes on-site, unannounced complaint investigations. Complaints are received through the SMA's complaint hotline, email, written correspondence and in-person with SMA staff. The SMA's hotline number is on posters required to be displayed in each floor of the SLP prov. building. Placement of posters is verified at the time of the initial certification review and annually thereafter. The hotline number is also included on the SMA's Resident Rights brochure that is distributed to waiver partic. during initial and annual assessments. SMA staff verifies the receipt of brochures during record reviews and interviews with a rep., random sample of continuous waiver partic. at each SLP provider annually.

Edits in the SMA's MMIS prevent prov. from billing the SMA for duplicative svcs. The SMA has duplicate claim checks for fee for svc. and encounter claims w/ MMIS. MMIS compares hospital claim data and will void a SLP claim if it overlaps with a hospital or nursing facility (NF) claim.

When a waiver partic. is admitted to a NF, the SLP prov. is required to discharge the partic. in the SMA's data interchange system. The NF enters an admission into the SMA's data interchange system. MMIS does not allow a client to have an admission to an SLP prov. and NF at the same time.

MMIS only allows payment to certified prov. The SMA certifies SLP prov. initially and annually. The SMA also processes Medicaid prov. enrollment. Until a SLP prov. is certified and enrolled as a Medicaid prov. by the SMA, MMIS will not allow payments to be issued. When an SLP prov. is terminated from the Medicaid program, MMIS prevents payment from being issued.

SLP prov. are certified by the SMA through an on-site review process prior to providing svcs. and annually. This includes a review of SLP prov. staff. The SMA verifies SLP prov. staffing and the qualifications of Certified Nurse Aides and licensed nurses, who provide personal care to waiver partic. The SMA verifies SLP prov. staff certifications, licensure and required criminal background checks.

The SMA's MMIS only allows payment to be issued to certified SLP prov. that are enrolled Medicaid prov. Payments are issued to the SLP prov., not individual SLP prov. staff who supply direct care and other svcs. SLP prov. receive a flat daily rate.

If the SMA discovers an SLP prov. is not supplying svcs. as outlined in the partic.'s plan of care, findings of non-compliance are cited. The SLP prov. has 30 days to develop and implement a plan of correction. The SMA performs an unannounced on-site follow up review. If non-compliance is still identified, the SLP prov. is given another 30 days to remediate. If the second unannounced on-site follow up review still identifies non-compliance, sanctions are issued up to and including provider termination. In this instance, SMA staff would assist partic. with transferring to a new prov.

Additionally, the SMA's Office of Inspector General (OIG) is notified if Medicaid fraud is suspected. The OIG can also involve the IL State Police in reviews of Medicaid fraud.

SLP prov. receive a daily per diem and the SMA's MMIS contains duplicate claim logic that will reject multiple claims for the same date of service. There are edits in the SMA's MMIS to prevent prov. from billing the SMA for managed care clients. When a partic. is enrolled in managed care, MMIS will not allow the SMA to issue a payment for any svcs. covered by managed care, including waiver svcs. If a prov. bills the SMA for a partic. for svcs. covered by managed care, the claim will reject with the "Recipient in MCO" message.

Additionally, the MCOs receive a monthly file from the SMA with information for SLP waiver partic. The report is generated from MMIS and includes MCO enrollment and SLP waiver eligibility. The SMA's contract with the MCOs states payment should not be issued prior to confirmation the partic. is included in the report.

Suspected abuse is reported to the SMA and local law enforcement. Substantiated abuse by an SLP provider results in findings of non-compliance being issued (see process above). A notice of immediate jeopardy is issued if it is determined by the SMA there is an immediate threat to partic. health and safety.

The SMA is accountable for the proper administration of the systems and procedures described above.

#### **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.

Payment for Non-waiver participant:

If the SMA discovers that payment has been issued for waiver services for an individual not enrolled in the waiver at all, or not enrolled for a certain period, a non-allowable service period is identified. The SMA would then recover any reimbursement made during the non-allowable service period. SMA staff manually change the admission date to the waiver or delete an admission date, as appropriate, in the long term care data base. This would result in MMIS making an automatic adjustment to reduce a future payment to the SLP provider.

If the individual problem is found to be the result of an error made by a Department of Human Services (DHS) caseworker, the SMA would communicate this to supervisory staff at DHS. The employee could receive clarification/training regarding correct entry in to the long term care database. Continued problems could result

in administrative personnel action.

Additionally, the SMA's Office of Inspector General (OIG) is notified if Medicaid fraud is suspected. If the OIG's investigation resulted in termination of a Medicaid provider agreement, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

**Incorrect Reimbursement Rate:**

If the SMA discovered an incorrect reimbursement rate was used to generate a payment for a waiver participant, the provider reimbursement database would be corrected to reflect the correct reimbursement rate. Correction to the reimbursement rate for waiver services would be generated automatically by MMIS based on the revised rate. This would result in an adjustment, either up or down, to future payment.

Additionally, the SMA's OIG would be notified if Medicaid fraud was suspected. If the OIG's investigation resulted in termination of a Medicaid provider agreement, SMA staff would assist waiver participants with identifying possible relocation options, including transferring to another SLP provider.

For those functions delegated to a contracted entity, the Plans are responsible for addressing individual problems as they are discovered. The SMA monitors both compliance and timely remediation through monitoring and reporting by the plans.

**ii. Remediation Data Aggregation**

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**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).

Supportive Living Program (SLP) rates were originally calculated based upon the weighted average reimbursement rate for nursing facilities in the same geographic area, excluding room, board and other Medicaid prohibited costs provided to participants. Establishment of the SLP rate at 60% of the nursing facility rate ensured provision of competitive, geographic-based rates to providers while guaranteeing the cost-neutrality of the waiver. SLP rates are not tied to the type of service or the frequency of services provided. However, the SLP provider must supply waiver services to meet participants' needs. Room and board rates, including meals, are paid directly by the participant to the SLP provider and are based on Supplemental Security Income amounts. These payments are separate from the SMA reimbursement rate for SLP services.

The reimbursement system for nursing facilities is a prospective system; that is, the rates are set for each facility for a subsequent rate period. The rates remain in effect for the rate period and there is no retroactive reconciliation of rates to actual expenditures during the rate period. The reimbursement rates are facility specific. Individual rates are set for each nursing facility, taking into account such factors as, individual facility costs, variations in patient case mix, geographic location, and other facility characteristics, such as occupancy level.

Nursing facility rates are developed using the MDS 2.0 item set and wage rates developed from provider cost reports. Nursing facility rates are developed using the nursing component only. Support, or administrative functions or capital functions are excluded from this rate. No other Medicaid service costs are included in the rate development.

The weighting method uses nursing facility paid claim days in the most current prior completed period by geographic region.

For non-dementia care SLP settings, this weighted average by geographic region was multiplied by 60 percent. Room and board charges for waiver participants are set by the SMA and are separate from the SLP provider rate.

The rate for SLP waiver dementia care settings is currently based upon 72% of the nursing facility rate, excluding room, board and other Medicaid prohibited costs. This percentage was developed using comparisons of resident care costs in nursing facilities providing dementia care with the rate paid by the SMA, which includes a specific add-on to the daily reimbursement rate (excluding room, board and related costs) for each participant receiving these services. Input was sought from the trade association representing SLP providers regarding actual program cost information and inclusion of other relevant costs, e.g. liability insurance. The SMA also consulted with representatives of the Illinois Alzheimer's Association to learn about other states' programs, as well as components of the reimbursement system used by the "private pay" assisted living market in Illinois. In all deliberations and calculations, SMA staff was careful to separate the cost of room and board charges paid by participants from any overall rate calculations.

The dementia care setting rate reflects the cost of increased staffing and services necessary to meet the scheduled and unscheduled clinical and supportive service needs of participants. For instance, a minimum of one certified nurse aide is required for every ten participants in a dementia care setting. Licensed nursing services are increased due to participants' needs for medication administration. Additional required services for dementia care settings that differ from a conventional SLP provider include well being checks at least once every shift and scheduled activities a minimum of three times daily. The unscheduled needs of participants in dementia care settings require more staff interaction as well. For example, increased verbal cuing, redirection and assistance with activities of daily living are provided by staff.

The SMA sought to strike a balance between giving providers a reimbursement rate that would allow them to provide safe, quality care to participants in need of dementia services, while still ensuring cost neutrality for the waiver. SMA staff analyzed nursing facility reimbursement rates for dementia services at various levels to ascertain what level of rate would result in cost effectiveness, while still offering providers a competitive rate. The rate of 72% was the highest percentage that could be justified and still result in cost neutrality.

Current reimbursement-rate methodology for conventional SLP providers and dementia care settings was separated from the nursing facility rate methodology in Public Act 97-0689. The SMA is currently working to develop a revised rate methodology for the Program which more accurately reflects the acuity level and resource utilization of participants. The transition from a flat daily rate to a stratified, acuity-based reimbursement system is part of a larger statewide project involving the implementation of a uniform assessment tool (UAT) for use in several of the State's long term care programs. Implementation of the UAT is a major deliverable associated with the State's participation in the Balancing Incentive Program (BIP) which requires implementation of a core standardized assessment for use with participants who utilize long term services and supports.

The InteRAI Community Health Assessment (CHA) has been adopted for use within the UAT in Illinois for long term services and supports, including several HCBS waivers. Implementation of the CHA is scheduled to begin in 2017 and will be rolled out across waiver programs and geographic areas in multiple waves.

Development and implementation of the new SLP stratified rate system will be informed by clinical assessment data collected through the CHA.

The rate paid to SLP waiver providers would be based on the acuity and resource utilization of their participant population instead of a flat daily rate. The stratified rate methodology would include reimbursement for waiver services identified in the CHA as a participant need and included in the individualized service plan. This would include activities of daily living, instrumental activities of daily living and services related to medical conditions/diagnoses, cognition and behavior needs. Room and board rates will remain separate and apart from the Medicaid service reimbursement rate.

Participants, providers and advocacy groups will be included in discussions regarding the new reimbursement system. Administrative rule changes will need to be adopted, which will require a public comment period. The SMA will submit a waiver amendment prior to implementation of a new reimbursement system, which would also include a public comment period. The SMA anticipates this could occur as early as WY2 of the waiver renewal.

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 Member Per Month (PMPM) 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:

Supportive Living Program (SLP) rates are set by the SMA. A flat rate is paid for all services provided each day a Medicaid participant resides in a SLP provider building. Historically SLP provider fee-for-service payments have been generated by the SMA based upon participant data entered into the SMA's long term care database by staff of the Department of Human Services (DHS) and SLP providers. Information regarding participant admission, third party liability coverage, income changes and patient credit updates, discharge and death are communicated electronically by providers to DHS staff. DHS staff enters participant admissions, income and patient liability into the SMA's long term care database. Provider submissions regarding discharge or death go live into the long term care database and do not require review and entry by DHS staff. This process is effective for services provided through November 30, 2016.

Effective December 1, 2016 and after, SLP providers submit electronic claims each month to the SMA for Medicaid participants via the Department's Internet Electronic Claim system. Providers follow the UB04 and 837I Implementation guidelines to submit claims. Claim information includes the dates a participant is in the SLP building, temporary absence days and third party liability coverage. Claims are verified with information in the long term care database to ensure payment is made for Medicaid eligible participants who have been admitted to a SLP provider building, per review and approval by DHS staff. This review also ensures the correct daily reimbursement rate is paid.

SLP providers are also paid by Managed Care Organizations (MCO) with which the SMA contracts. The MCOs, through the Integrated Care Program (ICP), Medicare Medicaid Alignment Initiative (MMAI) and Family Health Program (FHP), receive monthly capitated payments from the SMA and are responsible for managing and paying for the care of specific participants. The capitated payments are generated by the SMA's MMIS based upon a SLP participant's eligibility in the SMA's system for managed care and SLP services. The SLP providers bill the MCOs on a monthly basis and receive their payments directly from the MCO. The MCOs are required to have an internal process to validate payments to SLP providers, including a claims processing system verifying an individual's eligibility for SLP service. In addition, the MCOs are required to submit their paid claims to the SMA as encounter data that is processed through the SMA's MMIS to verify that payments were paid appropriately to Medicaid eligible providers for eligible participants.

A SLP provider representative must sign a remittance advice that accompanies each payment voucher to verify the provider accepts the payment amount is correct. The remittance advice and the signature certification documents must be kept on file by the SLP provider for three years. The SMA's Office of Inspector General audits these documents and reviews participant claims to verify they are paid in accordance with the waiver reimbursement methodology.

## **Appendix I: Financial Accountability**

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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:

Supportive Living Program (SLP) rates are set by the SMA. A flat rate is paid for all services provided each day a Medicaid participant (partic.) resides in a SLP provider building. Historically SLP provider fee-for-service payments have been generated by the SMA based upon partic. data entered into the SMA's long term care database by staff of the Department of Human Services (DHS) and SLP providers. Information regarding partic. admission, third party liability coverage, income changes and patient credit updates, discharge and death are communicated electronically by providers to DHS staff. DHS staff enters partic. admissions, income and patient liability into the SMA's long term care database. Provider submissions regarding discharge or death go live into the long term care database and do not require review and entry by DHS staff. This process is effective for services provided through November 30, 2016.

Effective December 1, 2016 and after, SLP providers submit electronic claims each month to the SMA for Medicaid partic. via the Department's Internet Electronic Claim system. Providers follow the UB04 and 837I Implementation guidelines to submit claims. Claim information includes the dates a partic. is in the SLP building, temporary absence days and third party liability coverage. Claims are verified with information in the long term care database to ensure payment is made for Medicaid eligible partic. who have been admitted to a SLP provider building, per review and approval by DHS staff. This review also ensures the correct daily reimbursement rate is paid.

The SLP provider is responsible for entering partic. discharges and deaths into the SMA's data interchange system within five days. Additionally, the SMA's long term care database cross references with a database from the Social Security Administration (SSA). If a death is not reported timely by the SLP provider, information from the SSA system interfaces with the long term care database and payments are automatically adjusted accordingly.

If a partic. transfers to a nursing facility and the SLP provider does not notify DHS, DHS would become aware of the discharge when the nursing facility submits admission information. Upon entry of the nursing facility admission information in to the database, the SMA would recover any payments made to the SLP provider after the partic.'s discharge. 89 IL Admin. Code 140.513 requires providers to notify the SMA within five business days of a change of resident status.

Hospital stays and vacations are reported to the SMA as temporary absences. In the event a SLP provider does not notify the SMA of a hospital stay, the system automatically cancels any payment to the SLP provider for the period of the hospitalization. Once the SLP provider submits the temporary absence information via an electronic claim, payment may be generated if the partic. has available temporary absence days. Any delays in notification are recognized by the payment system and payments are not made for claims submitted for these dates. The SMA's Office of Inspector General audits this process.

A SLP provider representative must sign a remittance advice that accompanies each payment voucher to verify the provider accepts the payment amount is correct. The remittance advice and the signature certification documents must be kept on file by the SLP provider for three years. The SMA's Office of Inspector General (OIG) audits these documents.

Claims are verified with information in MMIS to ensure payment is made for Medicaid eligible partic. who have been admitted to a certified, Medicaid enrolled, SLP provider building, per review and approval by the DHS staff. MMIS also includes edits to assure claims are not duplicative of nursing facility, hospital or MCO paid claims. The SMA's OIG audits the billing process. Inappropriate billings are either rejected by MMIS or voided, and are not included in the state's claim for Federal Financial Participation.

Monthly capitated rates are paid by the SMA to the MCOs (Plans). 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, per the MCO's contract with the SMA, MCOs are required to review their monthly payment and report any discrepancies to the SMA.

This payment is generated by MMIS based on participant's eligibility for waiver services as identified in the database system. The Plans only receive payment for individuals eligible for waiver services. 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 sent on to the State 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. The SMA then creates a HIPAA 820 file 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 complete 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 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:

- 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:

- 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

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### 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:

Supportive Living Program (SLP) buildings may be owned and/or operated by local housing authorities and local governments. These SLP providers do not differ from other providers in the type or amount of services they provide to waiver participants .

## Appendix I: Financial Accountability

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### 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:*

- 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.

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) (MCO) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
- This waiver is a part of a concurrent §1115/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (1 of 3)**

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

**Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (2 of 3)**

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source

or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

**Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

*Check each that applies:*

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

## Appendix I: Financial Accountability

### I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

**None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

**The following source(s) are used**

*Check each that applies:*

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## Appendix I: Financial Accountability

### I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

**No services under this waiver are furnished in residential settings other than the private residence of the individual.**

**As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

- b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Room and board rates are determined based on the Supplemental Security Income (SSI) payments available for individuals and married couples and are separate from reimbursement by the SMA for waiver services. Room and board costs are paid directly to the Supportive Living Program provider by the waiver participant. These rates increase whenever SSI amounts increase.

## 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:*

[Empty text box with scroll arrows]

**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:

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**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	14351.20	1490.00	15841.20	25930.60	1998.69	27929.29	12088.09
2	10847.37	1497.00	12344.37	26469.95	1912.15	28382.10	16037.73
3	10902.39	1504.00	12406.39	27020.53	1829.35	28849.88	16443.49
4	10956.11	1512.00	12468.11	27582.55	1750.14	29332.69	16864.58
5	11010.96	1520.00	12530.96	28156.27	1674.36	29830.63	17299.67

## 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	12132	12132	
Year 2	12465	12465	
Year 3	12666	12666	
Year 4	12965	12965	
Year 5	13167	13167	

## 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 estimated length of stay of 232 days for the waiver renewal is based upon the average LOS for State Fiscal Years (SFY) 2011 through 2015.

The estimated length of stay of 241 days for the waiver amendment is based upon the average LOS for State Fiscal Years 2013 through 2016.

## 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:

The estimated number of waiver participants was derived using State Fiscal Year (SFY) 2015 waiver participant totals and applying a formula to project growth based on the number of new SLP provider apartments expected to be certified during SFY 2018-2022 .

Factor D estimates are based on payment information from SFY 2015. The SMA is currently working to develop a revised rate methodology for the SLP which more accurately reflects the acuity level and resource utilization of participants (see Appendix I). The SMA will submit a waiver amendment prior to implementation of the new rate methodology. The SMA anticipates this could occur as early as Waiver Year 2.

For waiver participants receiving waiver services through a Managed Care Organization (MCO), a capitated rate specific to waiver services is used. The capitation rate is certified as actuarially sound. The capitation rate is developed based on the historical fee-for-service payments from SFY 2013-2015. The historical waiver 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 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.

- 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:

Factor D' estimates are based on ancillary payment information from State Fiscal Year (SFY) 2013-2015 , including both fee-for-service and MCO payments. Factor D' is estimated to increase 0.5% annually during SFY 2018-2022. This percentage is based upon the average historical percentage change for SFY 2013-2015, actual ancillary expenditures per capita for waiver participants and carried forward for SFY 2018-2022.

The capitation rate for waiver participants enrolled in Managed Care Organizations (MCO) includes both waiver services, as identified in Factor D, and ancillary medical and pharmacy services. The capitation rate will be developed based on historical costs for ancillary services for waiver participants from SFY 2013- 2015. The historical ancillary service expenditures will be trended forward to the contract rating years. Further, adjustment will be applied for policy and program changes, as well as anticipated managed care impact adjustments. The capitation rate also includes an administrative and risk load appropriate for the MCO.

Since not all waiver recipients are enrolled in an MCO, Factor D' will be developed based on a blend of those remaining in fee-for-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 estimates are based upon claims of recipients residing in nursing facilities age 60 years and over for State Fiscal Year (SFY) 2012-2015. The estimated SFY 2018-2022 average per capita has been increased by an estimated 2.08% based upon averages established over previous periods.

For recipients receiving nursing facility services through a Managed Care Organization (MCO), a capitation rate specific to nursing facility services is used. The capitation rate is certified as actuarially sound. The capitation rate was developed based on historical costs for nursing facility services from SFY 2013-2015. The historical nursing facility experience will be trended forward to the contract rate years. The capitation rate also includes an administrative 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' is based upon claims data for ancillary services for actual nursing facility residents age 60 years and over for State Fiscal Year (SFY) 2012-2015. The estimated SFY 2018-2022 average per capita has been decreased an estimated 4.33% based upon averages established over previous periods.

The capitation rate for nursing facility residents enrolled in Managed Care Organizations (MCO) includes both

nursing facility services, as identified in Factor G, and ancillary medical and pharmacy services. the capitation rate is certified as actuarially sound. The capitation rate is developed based on costs for ancillary services for nursing facility residents from SFY 2013-2015. The historical ancillary service expenditure will be trended forward to the contract rating years. The capitation rate also includes an administrative 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.

**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
Assisted Living

**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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							174108810.05
Assisted Living	<input type="checkbox"/>	day	6540	248.12	74.18	120372242.06	
Assisted Living MMAI	<input checked="" type="checkbox"/>	day	3072	222.50	39.90	27272448.00	
Assisted Living MLTSS	<input checked="" type="checkbox"/>	day	1993	248.12	45.22	22361432.90	
Assisted Living ICP/Disabled Adults	<input checked="" type="checkbox"/>	day	527	240.50	32.37	4102687.10	
<b>GRANDTOTAL:</b>							174108810.05
Total Services included in capitation:							53736567.99
Total Services not included in capitation:							120372242.06
Total Estimated Unduplicated Participants:							12132
Factor D (Divide total by number of participants):							14351.20
Services included in capitation:							4429.32
Services not included in capitation:							9921.88
Average Length of Stay on the Waiver:							241

**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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							135212516.85
Assisted Living	<input type="checkbox"/>	day	1041	150.00	74.51	11634736.50	
Assisted Living MMAI	<input checked="" type="checkbox"/>	day	3148	222.50	40.39	28290367.70	
Assisted Living MLTSS	<input checked="" type="checkbox"/>	day	7733	261.30	45.06	91049718.47	
Assisted Living ICP/Disabled Adults	<input checked="" type="checkbox"/>	day	543	240.50	32.45	4237694.18	
<b>GRAND TOTAL:</b>							135212516.85
Total Services included in capitation:							123577780.35
Total Services not included in capitation:							11634736.50
Total Estimated Unduplicated Participants:							12465
Factor D (Divide total by number of participants):							10847.37
Services included in capitation:							9913.98
Services not included in capitation:							933.40
Average Length of Stay on the Waiver:							241

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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							138089722.84
Assisted Living	<input type="checkbox"/>	day	1058	150.00	74.88	11883456.00	
Assisted Living MMAI	<input checked="" type="checkbox"/>	day	3198	222.50	40.59	28882017.45	
Assisted Living MLTSS	<input checked="" type="checkbox"/>	day	7858	261.30	45.29	92993748.67	
Assisted Living ICP/Disabled Adults	<input checked="" type="checkbox"/>	day	552	240.50	32.62	4330500.72	
<b>GRAND TOTAL:</b>							138089722.84
Total Services included in capitation:							126206266.84
Total Services not included in capitation:							11883456.00
Total Estimated Unduplicated Participants:							12666
Factor D (Divide total by number of participants):							10902.39
Services included in capitation:							9964.18
Services not included in capitation:							938.00

Average Length of Stay on the Waiver:

241

**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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Assisted Living Total:</b>							142046016.92
Assisted Living	<input type="checkbox"/>	day	1082	150.00	75.25	12213075.00	
Assisted Living MMAI	<input checked="" type="checkbox"/>	day	3274	222.50	40.80	29721372.00	
Assisted Living MLTSS	<input checked="" type="checkbox"/>	day	8044	261.30	45.51	95657341.57	
Assisted Living ICP/Disabled Adults	<input checked="" type="checkbox"/>	day	565	240.50	32.78	4454228.35	
<b>GRAND TOTAL:</b>							142046016.92
Total Services included in capitation:							129832941.92
Total Services not included in capitation:							12213075.00
<b>Total Estimated Unduplicated Participants:</b>							12965
<b>Factor D (Divide total by number of participants):</b>							10956.11
Services included in capitation:							10014.11
Services not included in capitation:							942.00
<b>Average Length of Stay on the Waiver:</b>							241

**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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Assisted Living Total:</b>							144981339.50
Assisted Living	<input type="checkbox"/>	day	1100	150.00	75.63	12478950.00	
Assisted Living MMAI	<input checked="" type="checkbox"/>	day	3325	222.50	41.00	30332312.50	

Assisted Living MLTSS	<input checked="" type="checkbox"/>	day	8168	261.30	45.74	97622808.82	
Assisted Living ICP/Disabled Adults	<input checked="" type="checkbox"/>	day	574	240.50	32.94	-4547268.18	
<b>GRAND TOTAL:</b>							144981339.50
Total Services included in capitation:							132502389.50
Total Services not included in capitation:							12478950.00
<b>Total Estimated Unduplicated Participants:</b>							13167
<b>Factor D (Divide total by number of participants):</b>							11010.96
Services included in capitation:							10063.22
Services not included in capitation:							948.00
<b>Average Length of Stay on the Waiver:</b>							241