

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. **Program Title:**

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)

01/01/27

Approved Effective Date of Waiver being Amended: 10/01/22

2. Purpose(s) of Amendment

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

The purpose of this amendment is to:

1. Request federal approval to implement Public Act 104-0470 which allows individuals age 44 to 64 with a dementia disability diagnosis, as defined by the Social Security Administration, to receive services in a supportive living dementia care setting if the individual meets all other eligibility requirements to receive services under 89 Ill. Adm. Code 146 Subpart B and E effective 1/1/2027, or upon CMS approval. Updated Appendix Main-2, B-1-A, B-3-F, and B-8 to include this language.
2. Update Appendices C-5, D-1-d, D-1-ii, and D-2-a to reflect changes resulting from the 3.7 software change.
3. Update Appendix D-1-d-i to include that the Person Centered Plan is signed by all providers responsible for the implementation of the person-centered service plan and a receive a copy of the plan.
4. Update Appendices F-3-b and F-3-c to include updated grievance procedures to meet the requirements in the Federal HCBS Access Rule.
5. Update Appendix I-2-a to include the State's recordkeeping practices for public input, to include the MA's comparative payment rate analysis and payment rate disclosure requirements in compliance with 42 CFR 447.203(b)(3), and the MA's payment rate transparency disclosure in compliance with 42 CFR 447.203(b)(1).
6. No changes made to Appendix J-2-d related to the individuals 44-64 with dementia becoming eligible for the waiver for WY5 since the current waiver projections were sufficient to cover the potential increase in customers for the remainder of WY5.

3. Nature of the Amendment

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

Component of the Approved Waiver	Subsection(s)
☒ Waiver Application	Main-2
☒ Appendix A - Waiver Administration and Operation	
☒ Appendix B - Participant Access and Eligibility	B-1-a, B-3-f, B-8
☒ Appendix C - Participant Services	C-5
☒ Appendix D - Participant Centered Service Planning and Delivery	d-1-d, d-1-ii, d-2-a
☐ Appendix E - Participant Direction of Services	
☒ Appendix F - Participant Rights	F-3-b, F-3-c
☐ Appendix G - Participant	

Component of the Approved Waiver	Subsection(s)
Safeguards	
☐ Appendix H	
☐ Appendix I - Financial Accountability	
☐ Appendix J - Cost-Neutrality Demonstration	

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

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

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

1. Request Information (1 of 3)

A. The **State** of **Illinois** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 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.005.05.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 10/01/22

Approved Effective Date of Waiver being Amended: 10/01/22

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 section 1915(a)(1)(a) of the Act and described in Appendix I**
- ☒ **Waiver(s) authorized under section 1915(b) of the Act.**

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

A 1915(b) waiver amendment was submitted to CMS on April 6, 2018. CMS approved this on October 23, 2018, and Illinois was allowed to expand Managed Long Term Supports and Services (MLTSS) statewide. The statewide expansion became effective and enrollments began July 1, 2019.

On October 1, 2019, the Department submitted to CMS a MLTSS 1915(b) request for waiver renewal for a period of 5 years beginning January 1, 2020. This request was approved by CMS on December 23, 2019.

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

- ☒ **section 1915(b)(1) (mandated enrollment to managed care)**
- ☐ **section 1915(b)(2) (central broker)**
- ☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **section 1915(b)(4) (selective contracting/limit number of providers)**
- ☒ **A program operated under section 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 customers 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 customers to enroll in MCO 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 customers who are Medicare eligible, or who are First Nation/Native Americans (Indians), except for voluntary enrollment as indicated in subsection E. (Populations and Geographic Area) of the SPA.

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

Specify the program:

The Medicare Medicaid Alignment Initiative (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 Department of Healthcare and Family Services (HFS), the state Medicaid Agency (MA), is responsible for the Supportive Living Program (SLP) waiver. Responsibilities included program oversight, monitoring, provider enrollment, processing federal claims, maintaining an appeal process, and eligibility.

The SLP offers services to customers age 65+ and persons with physical disabilities ages 22-64 who meet functional and financial eligibility criteria. Those that meet Medicaid eligibility are waiver customers. Those that do not meet Medicaid eligibility pay for waiver services with their own funds. Customers may transition in and out of Medicaid eligibility. Services offered are the same for both Medicaid and private pay customers. The percentage of Medicaid waiver customers in the SLP averages approximately 70%. This includes both MCO and fee-for-service (FFS) populations.

Customer need for SLP services is determined by local community agencies called Care Coordination Units (CCUs), which are under contract with the Illinois Department on Aging (IDoA), and by staff of the Department of Human Services (DHS). These staff evaluate applicants' need for long term services and supports (LTSS) using a standardized Determination of Need (DON) assessment instrument, the DON. Customers' rights and responsibilities are defined in brochures and validated during various points of the assessment process.

SLP provider licensed nurses and MCO case managers are responsible for development and implementation of the person-centered plan (PCP). Customers are provided with the opportunity to lead the PCP. Those customers that choose not to lead are still engaged at all levels of assessment and care planning. The customer and provider(s) responsible for the implementation of the PCP receive a copy of the PCP. Customers are encouraged to make their own decisions about the services they receive. The services provided are based on the customer's individual needs and preferences and are supplied in accordance with the PCP.

Services available under the waiver include: medication oversight, routine health assessments by licensed nurses, well-being checks, assistance with activities of daily living (ADLs), laundry, housekeeping, social and health promotion and arranging for necessary outside services.

SLP dementia care settings (DCS) afford individuals with cognitive impairments the option to remain in a community setting while providing the added safety intervention of delayed egress and other supports. All of the services and requirements in a conventional SLP setting are followed in DCS in addition to well-being checks three (3) times daily, scheduled activities at least three (3) times daily, increased staffing and additional staff training. Customers are assessed prior to admission and quarterly thereafter to verify that delayed egress is a needed safety intervention. If a customer is assessed and determined not to require this intervention, they may still reside in the SLP dementia care setting. If delayed egress is not an assessed safety intervention, the customer may leave the building anytime they choose. The customer and their designated representative are also provided referral information to other service options, including a conventional SLP setting.

The MA ensures that SLP providers meet all standards for certification before services may be provided to customers.

The MA monitors customer welfare, services, staff qualifications and training and quality. The MA is also responsible for identifying non-compliance, remediation and sanctions. The MA reviews monitoring outcomes to identify problematic trends and track the effects of remediation efforts to improve performance.

Illinois' mandatory managed care program, now called HealthChoice Illinois, operates statewide, offering providers the opportunity to contract with Managed Care Organizations (MCOs) in all Illinois counties. The HealthChoice program launched January 1, 2018. The Integrated Care Program (ICP), Family Health Plan/Affordable Care Act (ACA) Adults (FHP/ACA) and Managed Care Long Term Services and Supports (MLTSS) managed care programs are now incorporated in HealthChoice Illinois. Customers enrolled in the Medicare Medicaid Alignment Initiative (MMAI) are not impacted by HealthChoice Illinois. Illinois received approval from the federal Centers for Medicare and Medicaid (CMS) to jointly implement the MMAI program on February 22, 2013. Section 1915(c) waivers impacted by MMAI were amended at that time. MMAI contracts have been extended a couple of times, and the current contract is set through December 31, 2022.

Amendment IL.0326.05.02, effective 11/1/2023.

Two (2) meals/day are being added as a component of the existing waiver service and implementing legislation (Public Act 102-0699, effective 7/1/2022) requiring quality add-on rate payments for meeting quality thresholds for: staffing hours/resident day, number of unplanned hospitalizations, and number of outpatient emergency department visits.

Since the inception of the SLP as a Home and Community Based service in the mid-1990s, waiver customers were able to receive Supplemental Nutrition Assistance Program (SNAP) benefits and SLP providers were able to serve as SNAP retailers. In 2017, the United States Department of Agriculture (USDA) questioned the appropriateness of the arrangement under their

existing rules and regulations. Congress enacted legislation to grandfather-in existing SLP providers. This provision expired at the end of 2022. To ensure continued access to healthy meals, without SLP customers having to move to a nursing facility, the MA submitted an Appendix K waiver to use Section 9817 American Recovery Plan (ARP) funds for two (2) meals/day. The Appendix K waiver was approved 11/28/2022. This amendment is making the provision of two (2) meals/day a waiver service.

CONTINUED TO MAIN B OPTIONAL

3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- ☐ **Yes. This waiver provides participant direction opportunities.** Appendix E is required.
 - ☒ **No. This waiver does not provide participant direction opportunities.** Appendix E is not required.
- F. Participant Rights.** Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the quality improvement strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The state requests a waiver of the requirements contained in section 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 section 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 section 1902(a)(1) of the Act (*select one*):

- ☒ No
- ☐ Yes

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

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver

and given the choice of institutional or home and community-based waiver services.

- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are 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 section 1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR Part 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. 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 Part 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:

On XXXXXXX, this proposed waiver amendment was emailed to the tribal government and posted for public notice to the website of the Illinois Department of Healthcare and Family Services at <https://hfs.illinois.gov/info/legal/publicnotices.html> providing for a 30-day comment period ending XXXXX.

This proposed amendment was also provided via a non-electronic method of public distribution. A copy of the proposed amendment was posted at DHS local offices throughout the state, except in Cook County. In Cook County, the notice is available in the Office of the Director, Illinois Department of Healthcare and Family Services, 401 South Clinton Street, 1st Floor, Chicago Illinois. Additionally, within the public notice a telephone number is provided to request a paper copy of the proposed waiver amendment. The public notice invited comments via email or regular mail. Finally, the Illinois Department of Healthcare and Family Services emailed notification to SLP providers and trade associations. SLP providers posted the public notice in the building for customers and families.

Copies are also available at the following locations:

- Healthcare and Family Services 201 South Grand Avenue East Springfield, IL 62763
- Healthcare and Family Services 401 South Clinton Chicago, IL 60607

The draft waiver amendment will remain on the public website until final approval from CMS.

The State issued tribal notification on XXXXXXX.

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

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

7. Contact Person(s)

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

Winsel

First Name:

Pam

Title:

Senior Public Service Administrator

Agency:

Department of Healthcare and Family Services

Address:

201 South Grand Avenue East

Address 2:**City:**

Springfield

State:

Illinois

Zip:

62763

Phone:

(217) 782-6359

Ext:



TTY

Fax:

(217) 557-2349

E-mail:

pamela.winsel@illinois.gov

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:**

Illinois

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 section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Illinois

Zip:

Phone:

Ext:

☐

TTY

Fax:

(312) 793-1640

E-mail:

Attachments

Laura.Phelan@illinois.gov

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:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

CONTINUED FROM MAIN 2. Brief Waiver Description

The MA worked with stakeholders to incorporate a pathway for accountability in applying the quality add-on rate payments similar to what is done for nursing facility add-ons. These add-ons will be tied to quality metrics for: staffing hours/resident day, unplanned hospitalizations and emergency department visits. Data for the quality add-on rate payments will be collected and applied prospectively quarterly to the SLP providers' daily rate.

Amendment IL.0326.R05.04 effective 1/1/2027, or upon CMS approval:

Request federal approval to implement Public Act 104-0470 which allows individuals age 44 to 64 with a dementia disability diagnosis, as defined by the Social Security Administration, to receive services in a supportive living dementia care setting if the individual meets all other eligibility requirements to receive services under 89 Ill. Adm. Code 146 Subpart B and E.

CONTINUED FROM D-1-d-i: Service Plan Development process

i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative: The customer has the right to refuse services, so long as others are not harmed by the refusal (89 Ill. Admin. Code 146.250(e)(6)). The SLP provider must explain the potential consequences to the customer and/or his authorized representative and include the refusal in the PCP. The service plan must document any services that are refused by the resident ((89 Ill. Admin. Code 146.245d).

Appendix F. 1. Opportunity to Request a Fair Hearing continued:

Managed Care Organization (MCO)

If a customer enrolled in an MCO is appealing their eligibility to gain access into the waiver or remain on the waiver, the appeal will go through appeal processes explained earlier in F.1. If the customer is appealing the level of services being provided, the appeal will proceed through the MCO's appeal process since the MCO Care Coordinators are developing the person-centered plan (PCP) and authorizing services. Customers enrolled in an MCO may file for an internal appeal with the MCO and also have the right to request a fair hearing with final decision being made by the Medicaid Agency (MA). The MA's fair hearings process is the same for all customers, including those enrolled with MCOs. The MA is the final level of Appeal. MCOs are required to have a formally structured appeal system that complies with Section 45 of the Managed Care Reform and Patient Rights Act and 42 CFR. 438 to handle all Appeals subject to the provisions of such sections of the Act and CFR. (including, without limitation, procedures to ensure expedited decision making when a customer's health so necessitates). The MA reviews/approves the MCO's Appeal process guidelines, in compliance with MCO Contract Sections 5.30.2.1 and 5.21.1.10.

MCOs inform customers about the MA's fair hearing process in the customer handbook distributed at the time of enrollment (MCO Contract Section 5.21.8.4). Information about the fair hearing process is also published on the MCOs' websites and contained in the MCO Customer Handbooks. Appeal information is also provided whenever a customer requests it. A customer may appoint a guardian, caretaker relative, or provider to represent the customer throughout the appeal process. The MCO shall provide a form and instructions on how the customer may appoint a representative.

Per 42 CFR 438.402(c) (ii), a customer or an authorized representative, with the customer's written consent, may file an internal appeal. The customer may only initiate a State Fair Hearing after the customer has exhausted the internal appeals process within the customer's MCO. Per 42 CFR 438.406 (a), MCOs are required to help customers in filing an internal appeal or in accessing the fair hearing process including assistance in completing forms and completing other procedural steps. This includes providing interpreter services, translation assistance, assistance to the hearing impaired (including toll-free numbers that have adequate TTY/TTD) and assisting those with limited English proficiency. The MCO must make oral interpretation services available free of charge in all languages to all customers who need assistance. This is also required by the MCO Contract Section 5.21.4.3.

At the time of the initial decision by the MCO to deny a requested service or reduce, suspend or terminate a previously authorized service, a Notice of Adverse Determination is provided by the MCOs in writing to the customer. In addition, the MCOs provides a Notice of Appeal Resolution to the customer at the time of the internal grievance or appeal resolution. If the resolution is not wholly in favor of the customer, the customer may elect to request a fair hearing from the MA. The Notice of Appeal Resolution includes the description of the process for requesting a Fair Hearing.

Each MCO submits a quarterly Grievance and Appeals summary report to the MA. The format of each report is dictated by the MA (MCO Contract Section 5.30.3.11). The quarterly summary report of Grievances and Appeals filed by customers is organized by categories of medical necessity reviews, access to care, quality of care, transportation, pharmacy, LTSS services

and other issues. It includes the total grievance and appeals per 1,000 customers. Additionally, it includes a summary count of any such appeals received during the reporting period including those that go through fair hearings.

Finally, these reports include Appeals outcomes indicating whether the appeals were upheld or overturned. Appeals are reported separately for each waiver. The MA reviews and analyzes the grievance and appeals reports and compares the reports over time and across MCOs to analyze trends, outliers among MCOs and to assure that the MCOs are addressing areas of concern. Records of adverse actions and requests for appeals are maintained by the MCOs for a period of six (6) years, per MCO Contract Section 5.30.4 and Section 9.1.36.

The MA ensures that MCO customers are informed by the MCO about their Fair Hearing Process by reviewing and prior approving the Customer Handbook, Notice of Adverse Determination and any Notices of Appeal Resolution letters which must contain the customers' rights to a Fair Hearing and how to request such. The State's External Quality Review Organization (EQRO) also reviews such documents through a desk review and determines if the MCO is compliant during on-site visits. The State reviews/approves the MCO's appeal process guidelines.

The MCO informs the customer about their appeal and fair hearing rights verbally and in writing at the initial face-to-face visit with the customer at least annually, and as needed. Customers may appeal if services are denied, reduced, suspended, or terminated. In addition, appeals may be made any time the MCO takes an action to deny the service(s) of the customer's choice or the provider(s) of their choice; The appeal process is described in writing in the MCO's Customer Handbook which is reviewed with the customer by the MCO's Care Coordinator.

When services are denied, reduced, suspended, or terminated, or choice is denied, the customer is informed via a Notice of Adverse Determination. This notice includes (a) A statement of what action the MCO intends to take; (b) The reasons for the intended action; (c) The guidelines or criteria used in making the decision. The Notice of Adverse Determination also contains information on appealing the determination and how services can continue during the period while the customer's appeal is under consideration. The customer is also informed of the right to request, free of cost, access to all copies of relevant information.

The MCOs have a separate appeal process that occurs prior to the Fair Hearing process. If an appeal is upheld by the MCO, the MCO sends a Notice of Appeal Resolution letter. This letter contains instructions/information on the Fair Hearing process.

Copies of the documents, including Notices of Adverse Determinations, Notices of Appeal Resolution, and the opportunity to request a Fair Hearing, are maintained by the MCO in a database.

CONTINUED FROM APPENDIX F-3-C

The MCO must have a Grievance Committee for reviewing grievances registered by its customers (MCO Contract Section 5.40.6) and MCO customers must be represented on the Grievance and Appeal Committee. At a minimum, the following elements must be included in the Grievance process:

- A formally structured Grievance system that is compliant with Section 45 of the Managed Care Reform and Patient Rights Act and 42 C.F.R. Part 438 Subpart F to handle all Grievances subject to the provisions of such sections of the Act and regulations (MCO Contract Section 5.30), including, an attempt to resolve all grievances as soon as possible but no later than 90 days from receiving the grievance.

- A formally structured Grievance Committee that is available for customers. The Grievance Committee is an additional check in place for Grievances that cannot be handled informally and do not meet the separate procedures approved under the IL Managed Care Reform and Patient Rights Act. All customers must be informed that such a process exists. Grievances at this stage must be in writing and sent to the Grievance Committee for review.

- The Grievance Committee must have at least one (1) customer on the Committee. The MA may require that one (1) member of the Grievance Committee be a representative of the MA; -A summary of all Grievances heard by the Grievance Committee and by independent external reviewers and the responses and disposition of those matters must be submitted to the MA quarterly; and

- A customer may appoint a guardian, or caretaker relative to represent the customer throughout the Grievance process. The state has provided that MCO customers must exhaust the internal appeals process within the MCO before initiating a State Fair Hearing. Customers are notified of this through the MCO Customer Handbook, the Notice of Adverse Determination, and any appeal letters. MCOs also discuss the grievance and appeals process with the customer during the person-centered planning process.

Appendix A: Waiver Administration and Operation

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

- ☒ **The waiver is operated by the state Medicaid agency.**

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

- ☒ **The Medical Assistance Unit.**

Specify the unit name:

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

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.:*

Care Coordination Units perform initial level of care evaluations for both Fee For Service and Managed Care Organization (MCO) customers. For the MCO customers, the person-centered (PCP) development and ongoing monitoring is the responsibility of the MCO.

Illinois' mandatory managed care program, now called HealthChoice Illinois, began operating statewide effective January 1, 2018 offering providers the opportunity to contract with MCOs in all Illinois counties; additional MCOs will be available only to Cook County residents. The Integrated Care Program (ICP), Family Health Plan/Affordable Care Act (ACA) Adults (FHP/ACA) and Managed Long Term Services and Supports (MLTSS) MCO programs are now incorporated in HealthChoice Illinois. Customers enrolled in the Medicare Medicaid Alignment Initiative (MMAI) are not impacted by HealthChoice Illinois.

For those waiver customers enrolled in a MCO, the MCOs will be responsible for care coordination, PCP development and oversight, customer safeguards, prior authorization of waiver services, and quality assurance and quality improvement activities.

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

Appendix A: Waiver Administration and Operation

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

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

Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

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

The MA reviews the initial screening results forms completed by local Care Coordination Units (CCUs) staff for all new Supportive Living Program waiver customers annually.

In the MA's contract with Managed Care Organizations (MCOs) that provide waiver services, an External Quality Review Organization (EQRO) is responsible for MCO record reviews.

The MA has specified for each waiver performance measure the following: responsibility for data collection, frequency of data collection/generation, sampling approach, responsible party for data aggregation and analysis, frequency of data aggregation and analysis, data source and remediation. For each performance measure, the data source varies according to the performance measure. For many of the measures, the sources are MCO reports and EQRO HCBS record reviews. The data source for some measures include questions related to customer satisfaction with services. Data is collected by the MA or the MCO either by evaluating 100% of records or through a representative sample of records, based on the specific performance measure.

The MA contracts with an EQRO to monitor the MCOs compliance with waiver assurances. As part of the MA's quality oversight and monitoring of the waiver providers, the EQRO performs quarterly onsite audits of the customer's PCPs' through record reviews. Per the MA's contract with the EQRO, upon completion of record reviews, the EQRO provides a customer specific summary of findings by measure and a waiver specific summary report of findings and recommendations as appropriate. The report includes a summary of non-compliance related to specific performance measures; overall summary of record review findings; and recommendations for remediation of non-compliance. The EQRO produces a quarterly report on PMs based on record reviews. The MA reviews the reports for outliers and poor performing measures. The MA and EQRO work collaboratively to follow-up with the MCOs to ensure remediation occurs, including developing corrective action plans, within the required time frames. MCO contracts include sanctions for failure to meet requirements for submissions of quality and performance measures.

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The following describes the oversight of the Care Coordination Units (CCUs) and the Managed Care Organizations (MCOs).

Oversight of CCUs:

The Medicaid agency (MA) reviews the initial level of care evaluation forms completed by CCUs for new Supportive Living Program waiver customers annually. MA staff audit the forms to verify they are complete and accurate. Copies of incomplete or inaccurate initial level of care evaluations are provided to the CCU for remediation.

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 MA. The sources of discovery vary, and the sampling methodology for discovery is based on either a 100% review or the use of a statistically valid proportionate and representative sample. The type of sample used is indicated for each performance measure. The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a +/-5% margin of error.

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

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

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

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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☒	☐
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☐
Level of care waiver eligibility evaluation	☒	☒

Function	Medicaid Agency	Contracted Entity
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☒
Utilization management	☒	☒
Qualified provider enrollment	☒	☒
Execution of Medicaid provider agreements	☒	☐
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

A1: Number and percent of substantive waiver changes where Public Notice and Tribal notifications were completed in accordance with CMS regulations. Numerator: Number of substantive waiver changes where Public Notice and Tribal notifications were completed in accordance with CMS regulations. Denominator: Total number of substantive waiver changes.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Log of Substantive Changes

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

Data Aggregation and Analysis:

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

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

Performance Measure:

A2: Number and percent of Quality Management Committee (QMC) mtgs. between program staff and MA where the waiver's quality performance data was reviewed as specified in the waiver. N: Number of QMC mtgs. between program staff and MA where the waiver's quality performance data was reviewed as specified in the waiver. D: Total number of QMC mtgs.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Medicaid Agency Meeting Log

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

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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):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☐ Annually
	☒ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

A3: Number and percent of quarterly Quality Management Committee (QMC) mtgs. between MCOs and MA where the MCOs quality performance data was reviewed as specified in the waiver. **N:** Number of quarterly QMC mtgs. between MCOs and MA where the MCOs quality performance data was reviewed as specified in the waiver. **D:** Total number of QMC mtgs. where MCO quality performance data was reviewed.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Medicaid Agency Meeting Log

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

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

Data Aggregation and Analysis:

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

Performance Measure:

A4: Number and percent of active waiver participants compared to the approved waiver capacity. Numerator: Number of active waiver participants compared to the approved waiver capacity. Denominator: Total number of CMS approved waiver slots by waiver year.

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

Data Aggregation and Analysis:

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

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

Performance Measure:

A5: Number and percent of waiver customers receiving services that state they are able to participate in meaningful activities that help meet their goals/needs. Numerator: Number of waiver customers receiving waiver services that state they are able to participate in meaningful activities that help meet their goals/needs. D: Total number of customers 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):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with +/-5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ 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):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

A6: Number and percent of waiver customers who state they feel supported in making decisions to remain independent to the greatest extent possible. Numerator: Number of waiver customers who state they feel supported in making decisions to remain independent to the greatest extent possible. Denominator: Total number of customers 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):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval =

		95% confidence level with +/-5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

The Medicaid Agency (MA) will conduct routine programmatic and fiscal monitoring for both the Supportive Living Program (SLP) waiver and the MCOs.

The SLP waiver staff submits proposed policy changes to the MA for review and approval and the MA reviews and approves these changes.

The MA and SLP waiver staff meet on a quarterly basis to review program administration and to evaluate the system performance. The quarterly meeting provides opportunities to discuss trends, issues, and remediation activities.

The MA is responsible for following up on all overdue PCPs until remediation is complete.

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

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific Performance Measures (PMs), which are specified in the MA's contracts that provide waiver services. Contract details regarding MCO performance measures include numerators, denominators, sampling approaches, data sources, etc. MCOs submit the reports on a quarterly basis to a SharePoint site at the MA. MA staff review reports to ensure all required information is included in the report, as well as to identify any performance issues requiring follow up with a particular MCO.

Through its contract with the External Quality Review Organization (EQRO), the MA monitors both compliance of PMs and timeliness of remediation for those waiver customers enrolled in an MCO through customer satisfaction data and quarterly record reviews.

The MA's sampling methodology for the EQRO quarterly record reviews has been finalized. The EQRO is the entity responsible for monitoring MCOs. The MA's EQRO, will first determine the appropriate sample size for conducting sample by MCO and by Waiver, with proportional random samples based on an individual MCO's waiver program distribution. Final sample size will be adjusted based on the actual MCO eligible population; MCO sample sizes will ensure a 95 percent confidence level +/-5 percent margin of error. The MA will select samples by MCO and by OA fee-for-service population.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

A1: The Supportive Living Program (SLP) waiver staff submits outstanding substantive changes to the Medicaid Agency (MA) for approval. If remediation is not within 30 days, the SLP waiver staff reviews procedures and submits a plan of correction to MA. The MA follows-up to completion.

A2: The MA will require completion of overdue reports. The SLP waiver staff will submit a plan of correction within 30 days.

A3: The MA will require completion of overdue reports. The MCO will submit a plan of correction within 30 days.

A4: The SLP waiver staff and MA monitor to ensure slots remain below capacity. If slots are getting close or going over capacity, the MA will request a waiver amendment to increase capacity.

A5: The SLP waiver staff will inform the provider of interview responses. The SLP waiver staff will continue to follow-up with customer to determine satisfaction. If no change, SLP waiver staff will follow-up with the provider until resolution. Initial follow-up will occur within 30 days of the finding.

A6: The SLP waiver staff will inform the provider of interview responses. The SLP waiver staff will continue to follow-up with customer to determine satisfaction. If no change, SLP waiver staff will follow-up with the provider until resolution. Initial follow-up will occur within 30 days of the finding.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

☒ No

☐ Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ Aged or Disabled, or Both - General					
	☒	Aged	65		☒
	☒	Disabled (Physical)	22	64	
	☒	Disabled (Other)	44	64	
☐ Aged or Disabled, or Both - Specific Recognized Subgroups					
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Medically Fragile		☐	☐
	☐	Technology Dependent		☐	☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism		☐	☐
	☐	Developmental Disability		☐	☐
	☐	Intellectual Disability		☐	☐
☐ Mental Illness					
	☐	Mental Illness		☐	☐
	☐	Serious Emotional Disturbance		☐	☐

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

1. Be a U.S. citizen or legal alien.
2. Be a resident of the State of Illinois.
3. Be age 65 or over, or 22-64 with a physical disability or 44-64 with a dementia disability diagnosis.
4. Be Medicaid eligible.
5. Be at risk of nursing facility placement as measured by the Determination of Need (DON) assessment.
6. Ability to be maintained safely in the Supportive Living Program (SLP) provider setting with the required waiver services in the person-centered plan.

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 Preadmission Screening and Resident Review (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:

Customers with physical disabilities ages 22-64 experience will continue to be enrolled in the waiver when they turn 65. Available services are the same for all waiver customers and are based on required assessments, not on age. There is no maximum age limit for the waiver.

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	14099
Year 2	15246
Year 3	

Waiver Year	Unduplicated Number of Participants
	15705
Year 4	16245
Year 5	17168

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

There are no specific policies related to prioritization of waiver services or assessments. Customers that meet eligibility requirements are enrolled in the waiver upon completion of the waiver assessments. There is not a waiting list for services.

Customers in the Supportive Living Program (SLP) must be age 65 year or older, or ages 22-64 and have a physical disability or ages 44-64 with a dementia disability diagnosis, as determined by the Social Security Administration. The SLP also offers a dementia program at specifically 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 severally 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 customers, dementia program customers do not require 24 hours skilled nursing care.

All potential customers must be checked against two state and one national sex offender registration websites and have a tuberculin test in accordance with the Illinois Control of Tuberculosis Code and be free of active tuberculosis. If a potential customer is determined to have active tuberculosis at the time of application and did not have documentation from their physician that they were no longer contagious, they would not be admitted to the SLP provider community. SLP provider buildings are not able to manage active tuberculosis in a contagious individual, such as having airborne isolation rooms. In the event the individual had been in the building or interacted with SLP provider staff, the SLP provider would contact the local health department to make sure they were aware of the diagnosis and to receive further instruction. Potential customers denied entrance onto the waiver would be referred to their physician and/or local health department to determine the type of TB test to be administered, skin or blood. Once the potential customer tests negative or has documentation from their physician or local health department that they were no longer contagious, they would be admitted to the SLP provider community.

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

For customers who are enrolled in a Managed Care Organization (MCO), the State-established policies governing the selection of customers for entrance to the waiver remain the same as for all customers. Initial waiver eligibility is to be conducted by State contracted Care Coordination Units (CCUs) and Department of Human Services (DHS), Division of Rehabilitated Services staff. The CCUs and DHS staff use the same objective criteria for all customers. Selection of entrants does not violate the requirement that otherwise eligible customers have comparable access to all services offered in the waiver.

Customers 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 Medicaid Agency.

Appendix B: Participant Access and Eligibility

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

Waiver Phase-In/Phase-Out Schedule

Based on Waiver Proposed Effective Date: 10/01/22

08/17/2026

a. The waiver is being (select one):

- ☒ Phased-in
☐ Phased-out

b. Phase-In/Phase-Out Time Schedule. Complete the following table:

Beginning (base) number of Participants:

Phase-In/Phase-Out Schedule

Waiver Year 1 Unduplicated Number of Participants: 14099			
Month	Base Number of Participants	Change	Participant Limit
Oct	8700	92	8792
Nov	8792	18	8810
Dec	8810	19	8829
Jan	8829	19	8848
Feb	8848	18	8866
Mar	8866	18	8884
Apr	8884	19	8903
May	8903	18	8921
Jun	8921	18	8939
Jul	8939	19	8958
Aug	8958	19	8977
Sep	8977	1034	10011

Waiver Year 2 Unduplicated Number of Participants: 15246			
Month	Base Number of Participants	Change	Participant Limit
Oct	10011	21	10032
Nov	10032	21	10053
Dec	10053	21	10074
Jan	10074	170	10244
Feb	10244	22	10266
Mar	10266	22	10288
Apr	10288	22	10310
May	10310	21	10331
Jun	10331	21	10352
Jul	10352	21	10373
Aug	10373	136	10509
Sep	10509	22	10531

Waiver Year 3 Unduplicated Number of Participants: 15705			
Month	Base Number of Participants	Change	Participant Limit
Oct	10531	22	10553
Nov	10553	22	10575
Dec	10575	22	10597
Jan	10597	22	10619
Feb	10619	22	10641
Mar	10641	22	10663
Apr	10663	22	10685
May	10685	23	10708
Jun	10708	22	10730
Jul	10730	22	10752
Aug	10752	22	10774
Sep	10774	22	10796

Waiver Year 4 Unduplicated Number of Participants: 16245			
Month	Base Number of Participants	Change	Participant Limit
Oct	10796	22	10818
Nov	10818	22	10840
Dec	10840	23	10863
Jan	10863	130	10993
Feb	10993	23	11016
Mar	11016	23	11039
Apr	11039	23	11062
May	11062	23	11085
Jun	11085	23	11108
Jul	11108	23	11131
Aug	11131	23	11154
Sep	11154	24	11178

Waiver Year 5
Unduplicated Number of Participants: 17168

Phase-In/Phase-Out Schedule

Month	Base Number of Participants	Change	Participant Limit
Oct	11178	24	11202
Nov	11202	23	11225
Dec	11225	131	11356
Jan	11356	108	11464
Feb	11464	24	11488
Mar	11488	134	11622
Apr	11622	24	11646
May	11646	112	11758
Jun	11758	25	11783
Jul	11783	24	11807
Aug	11807	25	11832
Sep	11832	25	11857

c. Waiver Years Subject to Phase-In/Phase-Out Schedule

Year One	Year Two	Year Three	Year Four	Year Five
☒	☒	☒	☒	☒

d. Phase-In/Phase-Out Time Period

	Month	Waiver Year
Waiver Year: First Calendar Month	Oct	
Phase-in/Phase-out begins	Oct	1
Phase-in/Phase-out ends	Sep	5

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ☐ Section 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)

☐ Parents and Other Caretaker Relatives (42 CFR § 435.110)

- ☐ Pregnant Women (42 CFR § 435.116)
- ☐ Infants and Children under Age 19 (42 CFR § 435.118)
- ☐ 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 section 1902(a)(10)(A)(ii)(XIII) of the Act)
- ☒ Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in section 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 section 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 Affordable Care Act 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 spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)

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

☐ Aged and disabled individuals who have income at:

Select one:

- ☐ 100% of FPL
- ☐ % of FPL, which is lower than 100%.

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), 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 section 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 section 1924 of the Act.**

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

- ☒ **Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 period after September 30, 2027 (or other date as required by law).

- b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).**

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 period after September 30, 2027 (or other date as required by law).

- c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).**

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 section 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 customers equals the maximum income a customer can have and be eligible under 435.217 group.

- **The following dollar amount**

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

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

Specify:

- **Other**

Specify:

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

- **Not Applicable**
- **The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 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 § 435.735:

- 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 period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 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 customers equals the maximum income a customer can have and be eligible under 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 or 42 CFR § 435.735:

- 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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 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 Medicaid Agency (MA) 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 customers. The MA 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 Ill. Adm. Code 220.605, CCUs who perform initial level of care evaluations for potential waiver customers must be:

Minimum qualifications for Care Coordination Unit staff:

1. Be an R.N. or have a B.S.N, or have a B.A./B.S. 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 an LPN 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, OR
3. Be waived for persons hired/serving in this capacity prior to December 31, 1991. Provision of a waiver for care coordinators hired prior to December 31, 1991 was based on their years of experience. These care coordinators must maintain certification for a case manager and must follow in-service requirements.

Minimum Qualification for the Department of Human Services, Division of Rehabilitation Services staff:

Requires a Master's degree with major course work in rehabilitation, counseling, guidance psychology, 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 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 customers 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 (DON). Those customers identified through the screening process as needing nursing facility level of care are afforded the opportunity to select a Supportive Living Program 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 nursing facility. The extent and degree of a customer's need for long term care is determined based on consideration of pertinent medical, social and psychological factors as measured by application of the DON.

In order to be eligible for waiver services, the customer must be evaluated with the DON assessment and meet the minimum Level of Care. This assessment includes a Mini-Mental State Exam (MMSE) and a functional level of needs and unmet needs section. The functional status section assesses both activities of daily living (ADL) and instrumental activities of daily living (IADL). The activities include the following: eating, bathing, grooming, dressing, transferring, incontinence, managing money, telephoning, preparing meals, laundry, housework, outside of home, routine health, special health, and being alone. Each area is scored 0-3 for level of need, and 0-3 depending on the level of natural supports available to meet the need. The score of 0 is no need increasing up to total dependence with a score of 3. The MMSE measures cognitive functioning of the customers. Care Coordination Unit and Department of Human Services, Division of Rehabilitation Services staff receive training and guidelines for scoring each area consistently. The DON is the same criteria used to assess for nursing facility eligibility. The final score is calculated by adding the results of the MMSE, the level of impairment and the unmet need.

The comprehensive assessment is completed by the Supportive Living Program (SLP) provider's registered nurse near the time of the waiver customer's admission and annually thereafter. It must also be updated as needed to reflect any changes in condition. The Determination of Eligibility reevaluations are performed annually by the MA through examination of the customer's comprehensive assessment. 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.

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:

Care Coordination Unit staff and Department of Human Services, Division of Rehabilitation Services staff complete the Level of Care evaluations utilizing the DON as described above. Medicaid Agency (MA) staff complete reevaluations.

The DON assessment tool determines level of care eligibility for the waiver. The DON measures both activities of daily living and instrumental activities of daily living. The DON assesses fifteen areas including eating, bathing, grooming, dressing, transferring, continence, managing money, telephoning, preparing meals, laundry, housework, special health, routine health, outside the home and being alone.

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

For customers enrolled in an Managed Care Organization, 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:

Medicaid Agency (MA) 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*):

Medicaid Agency (MA) staff tracks when the last annual level of care reevaluations were completed for customers in a SLP provider setting and complete the next reevaluation within 12 months. When the reevaluations are scheduled, a list of current waiver customers residing with the SLP provider setting is compiled from the long term care database, which is part of Medicaid Management Information System (MMIS). An automated LOCD tool is created that includes forms for each customer on the list from the long term care database. MA staff completes the Level of Care Determination (LOCD) tool. The automated LOCD tool is reviewed by supervisory MA staff to verify LOCDs were completed for each waiver customer and that they were completed timely.

For customers enrolled in a Managed Care Organization, the MA will employ the same procedures to ensure its timely reevaluations of level of care.

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

Care Coordination Units (CCU) maintain written and electronic documentation related to all evaluations for a minimum of six years. CCUs are required to maintain records in a secure, confidential location that is readily accessible.

The Department of Human Services (DHS), Division of Rehabilitation Services (DRS) maintains electronic and written documentation of evaluations for seven years. Each hard copy case file is maintained in the DHS-DRS local office associated with the customer's case or DHS' central storage location in Springfield, Illinois. Records in Springfield are maintained until they have met all appropriate guidelines for storage. Staff may request records from the Springfield location when necessary. The electronic version maintained in WebCM is retained indefinitely.

The MA maintains written and electronic documentation of reevaluations for seven years. Files are maintained in field offices, central office and also a central storage location. Records in central storage are maintained until they have met all appropriate guidelines for storage. Staff may request the records from central storage when necessary.

For customers enrolled in a Managed Care Organization, the same maintenance of records is followed.

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:

B1: Number and percent of applicants for whom there is reasonable indication that services may be needed in the future who received level of care assessment prior to receipt of services. N: Number of applicants for whom there is reasonable indication that services may be needed in the future who received level of care assessment prior to receipt of services. D: Total number of applicants.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

- 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:

B2: Number and percent of FFS and MCO waiver customers reassessed, as specified the approved waiver, through the redetermination process of waiver eligibility every 12 months. Numer: # of FFS and MCO customers reassessed, as specified in the approved waiver, through the redetermination process of waiver eligibility every 12 months. Denomin: Total # of waiver customers who had reassessments due.

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):
--	---	---

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

Data Aggregation and Analysis:

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

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

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:

B3: Number and percent of all initial LOC determinations completed for FFS and MCO customers using the processes and instruments described in the approved waiver. Numerator: Number of all initial LOC determinations for FFS and MCO customers completed using the processes and instruments described in approved waiver. Denominator: Total number of initial LOC determinations completed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

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

Performance Measure:

B4: Number and percent of all re-evaluations completed for FFS and MCO customers using the processes and instruments described in the approved waiver.
Numerator: Number of all re-evaluations completed for FFS and MCO customers using the processes and instruments described in approved waiver. **Denominator:** Total number of re-evaluations completed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Level of Care Determination form

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly

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

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

The Medicaid Management Information System has built in edits to reject any admissions to the system that do not meet the level of care criteria for the Determination of Need. Providers cannot receive reimbursement for services when an admission is rejected.

The Medicaid Agency (MA) uses tracking logs to identify when customer level of care redeterminations are due.

For initial level of care determination delegated to the Department on Aging's contracted Care Coordination Units and Department of Human Services, Division of Rehabilitation Services, the MA is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation.

The MA's sampling methodology is based on 100% review.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

B1: 1. LOC is done/corrected upon discovery; 2. If eligible, no additional action; 3. If ineligible, admission date in Medicaid Management Information System (MMIS) is corrected by the Medicaid Agency (MA) and payment adjustment occurs. Remediation must be completed within 60 days. Additionally, remediation will follow the 89 Ill. Adm. Code 146.280 for provider non-compliance action. The Supportive Living Program (SLP) provider is presented the findings in writing. A plan of correction must be submitted to the Medicaid Agency (MA) within fourteen days of receiving the findings of non-compliance. The plan must be implemented within thirty days. MA 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, MA staff would assist customers with relocation, including transfer to another SLP residence.

B2: 1. LOC is done/corrected upon discovery; 2. If eligible, no additional action; 3. If ineligible, admission date in MMIS removed by the MA and payment adjustment occurs; 4. Individual staff training as appropriate. Customer receives assistance with accessing other supports and services. Remediation must be completed within 60 days.

B3: If it is discovered that the initial level of care (LOC) was not completed using the processes and instruments described, the Care Coordination Unit (CCU) or Department of Human Services, Division of Rehabilitation Services (DHS/DRS) would be required to complete a new initial LOC. If the new initial level of care does not result in the required scoring, the

waiver eligibility will be discontinued and the MA will assist the customer with accessing other supports and services. Federal claims will be adjusted and MA, the Department Aging or DHS/DRS will provide technical assistance or training to Care Coordinators/assessors. Remediation must be completed within 60 days.

B4: 1. Re-evaluation corrected/completed upon discovery; 2. If eligible, no additional actions; 3. If ineligible, admission date in MMIS is removed by the MA and payment adjustment occurs; 4. Individual staff training as appropriate; 5. Waiver eligibility will be discontinued and the MA will assist the customer with accessing other supports and services. Remediation must be completed within 60 days.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

☒ No

☐ Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

At the time of the initial level of care evaluation, all potential waiver customers are informed of feasible service options for either waiver services or institutional care. A customer may choose at any time not to receive services for which eligibility has been determined. Department on Aging Care Coordination Units, Department of Human Services, Division of Rehabilitation Services staff and Managed Care Organization (MCO) Coordinators discuss service options, including institutionalized care and Home and Community Based Waiver services, and ensure that the customer is fully aware of the pros and cons of each option.

The statement regarding choice is on the Department on Aging's Participant Consent form, used by contracted Care Coordination Unit staff, which customers verify by signature at the time of the initial assessment that they were offered a choice of home and community-based services versus institutional care. Freedom of choice is also discussed in the Rights and Responsibilities brochure that is given out to customers at each assessment. Care Coordinators are required to show evidence of the customer's acknowledgement of receipt of the brochure in his/her documentation in the case notes.

Department of Human Services, Division of Rehabilitation Services staff inform customers of feasible alternatives to placement in a nursing facility and provide information about how to apply for home and community-based waiver services for which they may be eligible.

Initially and annually during the person-centered planning (PCP) process, fee for service customers are given the opportunity to choose Supportive Living Program waiver services, or be referred to Care Coordination Unit or Department of Human Services, Division of Rehabilitation Services staff to receive information regarding other waiver programs or institutional services for which they may be eligible. Customer preference is verified by the customer's signature and initials on the PCP form. By signing and initialing this form, customers acknowledge that they have been given a choice between waiver services and institutional care and are choosing to receive waiver services from the Supportive Living Program provider.

For customers enrolled in a Managed Care Organization (MCO), preference for institutional or home and community-based services will be documented on a Freedom of Choice form provided by the MCO and approved by the Medicaid Agency. The customer must sign the completed form indicating his/her choice and that he/she has made an informed choice.

MCOs are required to enter into contracts with any willing and qualified certified Supportive Living Program provider as long as the provider agrees to the MCO's rate and adheres to the MCO's quality assurance requirements. MCO Care Coordinators are trained to educate customers and provide an informed choice on the available providers and description of HCBS setting, if service is to be delivered outside of the home. For customers who do not express a choice amongst available contracted providers, the MCO shall fairly distribute such customers, taking into account all relevant factors, among those providers who are willing and able to accept the customer and who meet applicable quality standards.

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

For fee-for-service customers, the Care Coordination Units (CCUs) must maintain all written and/or electronic documentation and forms related to all evaluations, reevaluations and customer care are maintained for a minimum period of six (6) years after the contract terminates under which the customer was served. Active customers records can never be purged regardless of contract termination dates. CCUs are required to maintain records in a secure, confidential location that is readily accessible during this period. Records are kept securely at the local CCUs or at a secure storage facility until they can be purged by the CCU.

The Department of Human Services, Division of Rehabilitation Services, maintain documentation for a total of seven (7) years. Files are kept on site at the local Home Services Program (HSP) office for two (2) years and then transferred to the State Records Center in Springfield, Illinois for five (5) years at which time it will be disposed of, providing all audits have been completed and under the supervision of the Auditor General, and no litigation is pending or anticipated.

Supportive Living Program providers must maintain records for three years. Records must be kept on-site for a minimum of 12 months. Records from the previous 24 months may be stored off-site in a secure, confidential location that is readily accessible during this period.

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The State provides access to waiver services to all eligible seniors and persons ages 22-64 with physical disabilities and persons aged 44-64 with a dementia disability diagnosis in Illinois, including Limited English Proficient persons. Providers of the Supportive Living Program waiver serving Limited English Proficient persons are required to take steps to ensure equal access to services for customers. 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 customers must be in a language and format they can understand.

For customers enrolled in a Managed Care Organization (MCO), the MCO provides written materials distributed to English speaking customers, as appropriate, available in Spanish and other prevalent languages, as determined by the MA. Where there is a prevalent single-language minority within the low-income households (5% or more such households) where a language other than English is spoken, the MCO'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 customers includes 24-hour onsite response capability to meet scheduled or unpredictable customer 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 customer apartments and common areas of the building. The system is connected to a Supportive Living Program (SLP) setting's emergency call system monitored by nursing and response personnel. Other services include: well-being checks, laundry, housekeeping, two 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.

Two meals per day shall meet the basic food pattern for a general diet for an adult following the recommendations of the Food and Nutrition Board, National Academy of Sciences.

Case management services are provided to assist customers 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 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 customers with obtaining such services.

All assisted living services are provided by employees of the SLP provider. Staff provides individualized customer services based on the comprehensive assessment and a customer's preferences as determined through the person-centered planning (PCP) process. All customers are entitled to receive all of the services provided by the SLP. Customers and others of their choosing, such as a family member, are involved with the development of the PCP. Customers are able to identify which services they would like to receive and the frequency of services. The Medicaid Agency monitors SLP providers to ensure that individualization occurs and verifies that customer 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 customer resides in a SLP setting 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 customer's PCP. 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 I-5.

Customers 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 delayed egress as needed for a safety intervention. Dementia care settings also have secured outdoor areas for use by customers who require this as a needed safety intervention. Customers are evaluated at the time of admission and quarterly thereafter to assess the continued need for delayed egress as a safety intervention. If a customer/potential customer is assessed and determined not to require this intervention, they may still reside in the SLP dementia care setting. The individual/their designated representative are also provided referral information to other service options, including a conventional SLP setting.

Amendment IL.0326.05.03, effective 1/1/2025, or upon CMS approval.

Certified Medication Aides may administer medications under the supervision and delegation of a registered nurse, who will

be present in the SLP building, as authorized in Section 50-75 of the Illinois Nurse Practice Act, except where (i) Schedule II controlled substances as set forth in the Illinois Controlled Substance Act and (ii) any subcutaneous, intramuscular, intradermal, or intravenous medication.

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 customers. Supportive Living Program providers must meet the scheduled and unscheduled needs of customers (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
- ☐ Remote/via Telehealth

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 Medicaid Agency (MA). 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 customers. It continues on an annual basis through an on-site review process. Initial certification by the MA 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 customer 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:

Medicaid agency.

Frequency of Verification:

The Medicaid agency verifies provider qualifications at the time of initial certification and during annual on-site annual certification reviews conducted for 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 section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☒ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

Case management responsibilities are shared by the Medicaid Agency (MA) and Supportive Living Program SLP providers. Each entity has a specific role and duties. SLP provider staff is required to complete scheduled assessments initially, quarterly and annually. Assessments are also performed if a customer experiences a change in condition. SLP providers must develop and implement individualized person-centered plans (PCPs) based on customer's needs and preferences identified in the PCP and voiced by the customer. PCPs are required to be revised when a change in condition occurs and reviewed in conjunction with quarterly and annual assessments. Additionally, SLP providers must provide assistance with arranging for and coordinating outside service for waiver customers. Examples include: home health services, physician visits and therapy services. Ancillary services are another case management component supplied by SLP providers. SLP staff must arrange transportation for waiver customers to medical appointments and offer to help with activities like shopping.

The MA performs case management services by conducting annual level of care determinations for all waiver customers, reviewing customer assessments and PCPs, addressing problems in service provision, monitoring the implementation of PCPs and observing customer health and safety.

The MA staff monitors and provides oversight for SLP case management functions. During annual on-site certification reviews, records of a sample of customers are reviewed. The MA verifies customer assessments were done timely and completed accurately and thoroughly. PCPs must be individualized and contain all of the customer's needs and preferences. This includes any outside services that are being provided to the customer. Progress notes, physician orders and other documentation in the record are also used to verify case management services. Customer interviews are also conducted and documented by MA staff.

For customers enrolled in an MCO, case management for overall health care, including waiver services is 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 assessment 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 PCP. The MCO Care Coordinator works in partnership with the SLP provider staff to make sure the PCP is comprehensive and person-centered. MCO 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 MCO Care Coordinator works with the member to ensure the PCP:

- 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, Primary Care Provider, other providers, family, etc. to participate and provide input into the PCP; and
- identifies risks, cultural preferences, preferred characteristics and language, living arrangements, barriers.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

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):

(a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted;

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 customers, or access to the living quarters or the financial, medical or personal records of customers, to undergo a criminal background check.

The 89 Ill. Adm. Code 146.235(l) 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".

(b) the scope of such investigations (e.g., state, national)

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 unlicensed 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 (IDPH). 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 process.

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.

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.

(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):

Annual on-site certification reviews are performed by the Medicaid Agency (MA) 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.

The MA is responsible for certifying SLP providers initially and annually thereafter, including verifying staff certification, licensure and compliance with the HCWBC Act. MCOs can only contract with SLP providers certified by the MA. Because of this, MCOs are not required to complete or verify background checks for SLP provider staff.

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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. 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):

(a) the entity (entities) responsible for maintaining the abuse registry;

The Illinois Department of Public Health (IDPH) maintains the Health Care Worker Registry.

(b) the types of positions for which abuse registry screenings must be conducted;

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 customers, 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 fingerprint 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 dietitians, 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.

(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):

Annual on-site certification reviews performed by the Medicaid Agency (MA) at SLP settings 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 MA 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)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "*extraordinary care*", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

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

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

Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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 Medicaid Agency (MA) does not limit any willing and qualified provider who choose to apply to the Supportive Living Program (SLP). An extensive process is utilized by the MA to review applications from providers wishing to participate in the SLP. Provider qualifications are published in MA rules (89 Ill. Adm. Code 146.215) and are located at the Department's website.

To ensure quality services for customers, the MA employs a thorough review process for applicants. Interested providers must submit an application and may undergo an in-person interview with MA 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 MA 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 MA, with the agency's SLP coordinators overseeing distribution, tracking, review and recommendations returned to the MA'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 MA. The MA 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.

Provider qualification can be found at <https://www.ilga.gov/commission/jcar/admincode/089/089001460B02150R.html>.

For HealthChoice Illinois, Managed Care Organizations (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.

Outside of the waiver, the State licenses assisted living and shared living establishments in each of its 102 counties.

MCO Care Coordinators are also required to enable as much choice as possible with the MCOs offering options of providers in order to accommodate customer preferences and choice. MCOs must offer contracts to all willing and qualified providers in the contracting area that offer HCBS waiver services, as long as the provider adheres to the MCO's quality requirements (Section 5.7.1.2 of MCO contract). By terms of their contract with the MA, the MCO must enter into contracts with a sufficient number of such Providers within each county in the Contracting Area to assure that the Affiliated Providers served at least eighty percent (80%) of the number of customers in each county who were receiving such services on the day immediately preceding the day such services became Covered Services. For counties served by more than one (1) Provider of such Covered Services, Contractor shall enter into contracts with at least two (2) of such

Providers, so long as such Providers accept Contractor's rates, even if one (1) served more than eighty percent (80%) of the customers, unless the MA grants Contractor an exception. All MCOs provide statewide coverage, with the exception of CountyCare, which covers Cook County, only. County Care must offer contracts to all providers in Cook County.

SLP Enrollment Process for Long-Term Care Enrollment:

The Illinois Department of Healthcare and Family Services (HFS) Bureau of Long-Term Care (BLTC) receives notification from the Supportive Living Provider (SLP) coordinator there is a new SLP program provider along with the name and address of the SLP, Category of Service (COS), total/max number of apartments for each COS (if applicable), and the effective date. The enrollment team then reaches out to the SLP contact and request the W-9 form and IRS letter, if not already received.

Once the W-9 form and IRS letter are received from the contact, the enrollment team forwards the documents to the Illinois Comptroller's Office for review and to certify the facility as a vendor. *Note: Once the documents are sent to the Comptroller's Office it takes approximately 14 business days to review and certify.

Once the vendor has been certified by the Comptroller's Office, the enrollment team notifies the SLP contact to let them know to complete an application on the Illinois Medicaid Advanced Cloud Technology (IMPACT) portal.

Once the SLP contact has completed an application through the IMPACT portal, the enrollment team verifies all information in IMPACT matches that received from the SLP program coordinator and Comptroller.

Once the IMPACT information has been verified and is correct, the enrollment team approves the application in IMPACT. * Note: IMPACT applications need to be approved by approximately 10:00am on Wednesday to back feed into HFS Payment system the next day. If approved after 10:00am on Wednesday, then it will back feed the following Thursday.

When the information has back fed into the Medicaid Management Information System (MMIS), the enrollment team verifies the information has correctly uploaded into the MMIS system.

Once the information has been verified, the Provider Participation Unit (PPU) is notified to update several screens in MMIS that do not back feed from IMPACT.

When PPU notifies the enrollment team that the MMIS screens have been updated, the SLP contact is then notified that they are now enrolled in the Medicaid program. The following is then provided to them: Medicaid provider identification number, provider name, payee name, and Payee identification number. The provider can now start to submit the SLP resident admissions into the Medical Electronic Data Interchange (MEDI) system.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one:*

- ☒ **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ☐ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions. By checking the boxes below, the state assures:**
 - ☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
 - ☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
 - ☐ **The HCBS must be identified in the individual's person-centered service plan; and**
 - ☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

And specify: (a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting; (b) How the 1915(c) HCBS will assist the individual in returning to the community; and (c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

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:

C1: Number and percent of newly enrolled certified waiver service providers that meet provider requirements in the approved waiver prior to providing waiver services. N: Number of newly enrolled certified waiver service providers that meet provider requirements in the approved waiver prior to providing waiver services. D: Total number of newly enrolled certified waiver service providers.

Data Source (Select one):

Other

If 'Other' is selected, specify:

HFS IMPACT System

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

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

Data Aggregation and Analysis:

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

Performance Measure:

C2: Number and percent of enrolled certified waiver providers that continue to meet provider requirements in the approved waiver prior to continuing to provide waiver services. N: Number of enrolled certified waiver providers that continue to meet provider requirements in the approved waiver prior to continuing to provide waiver services. D: Total number of enrolled certified waiver providers.

Data Source (Select one):

Provider performance monitoring

If 'Other' is selected, specify:

HFS IMPACT System

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

Data Aggregation and Analysis:

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

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

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

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

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:

C3: Number/percent of certified Supportive Living Program (SLP) providers that supply training as required by Department policy. Numerator: Number of SLP providers that supply training as required by Department policy. Denominator: Total number of SLP providers.

Data Source (Select one):

Training verification records

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly

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

Performance Measure:

C4: Number and percent of new MCO Care Coordinators who receive training in accordance with state requirements and the approved waiver prior to providing waiver services. N: Number of new MCO Care Coordinators who receive training in accordance with state requirements and the approved waiver prior to providing waiver services. D: Total number of new MCO Care Coordinators.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MCO Reports

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

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

Data Aggregation and Analysis:

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

Performance Measure:

C5: Number and percent of MCO Care Coordinators who receive training in accordance with state requirements and the approved waiver prior to continuing to provide waiver services. N: Number of MCO Care Coordinators who receive training in accordance with state requirements and the approved waiver prior to continuing to provide waiver services. D: Total number of MCO Care Coordinators.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

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

The Medicaid Agency (MA) conducts a compliance review for each Supportive Living Program (SLP) provider prior to certification and annually thereafter. The SLP provider is presented any findings of non-compliance in writing. A plan of correction must be submitted to the MA within fourteen days of receiving the findings of non-compliance. The plan must be implemented within thirty days. MA 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, MA staff would assist customers with relocation, including transfer to another SLP residence.

The MA is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by the Managed Care Organizations (MCO).

For those functions delegated to the MCO, the MA is responsible for discovery. MCOs are required to submit quarterly reports, using the format required by the MA, on specific performance measures (PM), which are specified in HFS' contracts with HealthChoice Illinois MCOs. All MCOs on contract with the MA provide waiver services. Contracts specify numerators, denominators, sampling approaches, data sources, etc. Through its contract with the External Quality Review Organization (EQRO), the MA monitors both compliance of PMs and timeliness of remediation for those customers enrolled in an MCO through consumer surveys and quarterly record reviews. Customers in MCOs are included in the representative sampling.

Additionally, the MA has developed queries within its HFS Electronic Data Warehouse to review provider qualifications. The MA pulls reports by waiver provider type for both licensed and unlicensed providers to assure that they initially met and continue to meet all the Illinois Medicaid Advanced Program Cloud Technology (IMPACT) system screening criteria and do not have any Office of Inspector General restrictions including exclusions or sanctions against their licenses. This is done for newly enrolled providers as well as existing providers. The reports are reviewed and discussed annually at one of the quarterly Quality Management meetings.

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 and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

C1: If a newly certified waiver provider fails initial IMPACT screening requirements, the MA informs provider of disposition of application and does not enroll in the Medicaid system.

C2: If an existing provider fails monthly screening by the MA or Medicaid provider revalidation, the MA notifies the provider of the results and disenrolls the provider.

C3: The training requirements will be completed. The Supportive Living Program (SLP) provider is presented findings of

non-compliance in writing. A plan of correction must be submitted to the MA within fourteen days of receiving the findings of non-compliance. The plan must be implemented within thirty days. MA 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, MA staff would assist customers with relocation, including transfer to another SLP residence.

C4: If the MCO Care Coordinator has not met required credentials or completed the required initial training, they are prohibited from performing Care Coordination functions until completed. The MCO Care Coordinator will gain the required credentials and/or complete training within 60 days.

C5: If the MCO Care Coordinator credentials lapse or does not complete the required initial training, they are prohibited from performing Care Coordination functions until completed. The MCO Care Coordinator will regain credentials and/or complete training within 30 days.

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>):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

☒ No

☐ Yes

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

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

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

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

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

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

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

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

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

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

Appendix C: Participant Services

C-5: Home and Community-Based Settings

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

1. Description of the settings in which 1915(c) HCBS are received. (*Specify and describe the types of settings in which waiver services are received.*)

The Medicaid Agency only utilizes residential provider settings for the provision of the Supportive Living Program. These settings meet the federal home and community-based settings requirements at 42 §§ CFR 441.301(c)(4)-(5).

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

Prior to enrollment as a Medicaid Agency (MA) approved provider, the MA completes an initial compliance review of the Supportive Living Program (SLP) providers to ensure compliance with home and community-based services (HCBS) federal settings requirements. Ongoing HCBS Settings compliance oversight is part of annual onsite certification reviews at SLP provider communities. These reviews are completed by MA registered nursing staff and include review of provider policies and procedures and other documentation, observations and customer interviews. Interview questions are designed to assess provider compliance with HCBS settings requirements based on customer perspectives and ongoing experiences receiving HCBS in the greater community, including opportunities for paid employment or volunteering and control of personal resources. Customer person-centered plans (PCPs) are also reviewed by the MA and its contracted External Quality Review Organization (EQRO) to ensure services are based on customer needs, strengths, and preferences, and include individual goals and supports needed to meet desired outcomes. Results are discussed with the provider and, depending on the nature of the findings, a plan of correction is required by the MA. The MA also completes unannounced investigations for complaints received. Review results are discussed with the MA's waiver unit during quarterly compliance meetings.

The MA utilizes a standardized review process and a review tool to ensure review completeness, and adherence to State and Federal regulations, including Federal person-centered planning and HCBS settings requirements.

The MA works with provider settings to resolve any non-compliance concerns received by the MA's administrative office or observed during initial and ongoing compliance reviews. This process includes written notification to the provider setting of the non-compliance concern(s) and a timeline for remediation via an approved corrective action plan. If the SLP provider is unable to resolve the concern, the MA ensures the provider setting is either issued sanctions or unfunded as an HCBS provider. The MA collaborates with the customer and case manager to broker alternate service options to impacted customers.

3. By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:

- ☒ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**
- ☒ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (see Appendix D-1-d-ii)**
- ☒ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**
- ☒ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**
- ☒ **Facilitates individual choice regarding services and supports, and who provides them.**
- ☒ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. *(Specify whether the waiver includes provider-owned or controlled settings.)*

- ☐ No, the waiver does not include provider-owned or controlled settings.
- ☒ Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements*, will meet the following additional conditions):
 - ☒ The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
 - ☒ Each individual has privacy in their sleeping or living unit:
 - ☒ Units have entrance doors lockable by the individual.
 - ☒ Only appropriate staff have keys to unit entrance doors.
 - ☒ Individuals sharing units have a choice of roommates in that setting.
 - ☒ Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
 - ☒ Individuals have the freedom and support to control their own schedules and activities.
 - ☒ Individuals have access to food at any time.
 - ☒ Individuals are able to have visitors of their choosing at any time.
 - ☒ The setting is physically accessible to the individual.
 - ☒ Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan (*see Appendix D-1-d-ii of this waiver application*).

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Person-Centered Plan (PCP)

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. (*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:

Fee for Service:

The Supportive Living Program providers' Registered Nurse (RN) is responsible for the development of the person-centered plan (PCP). The RN must have an active nursing license in the State of Illinois.

Managed Care Enrollees:

For customers enrolled in a Managed Care Organization (MCO), the MCO Care Coordinators are responsible for PCP development. MCO Care Coordinators are assigned based on customer need and identified risk. The Care Coordinators are required to complete 20 hours of training initially and annually, as specified in the MCO contract. MCO Care Coordinators must be trained on topics specific to the HCBS waiver customer they are serving. For the Supportive Living Program waiver, training must include Aging and Disability subjects .

☐ **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. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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. *Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

Customers may choose among Supportive Living Program (SLP) providers. By selecting a SLP provider and executing a resident contract, the customer accepts the services that the SLP provider is obligated to provide under the SLP. The resident contract must include information regarding the services the customer will receive from the SLP provider that are covered under Medicaid (89 Ill. Adm Code 146.240(b)(1)). A customer is free to cancel a resident contract and transfer to another service provider or choose to participate in another program at any time. The option to end the resident contract is included in the resident contract approved by the Medicaid Agency (MA).

Fee for Service:

The SLP provider RN is responsible for the development and implementation of the person-centered plan (PCP) (89 Ill. Adm. Code 146.245(d)). In addition to the PCP, an RN is responsible for the initial assessment, comprehensive resident assessment, and quarterly evaluations (89 Ill. Admin Code 146.245(b), (c) and (e)). Other nursing services include: medication set-up, administration and episodic and intermittent health promotion or disease prevention (89 Ill. Admin. Code 146.230(b)(1-4)). For services not provided by the waiver, such as physical therapy, a customer may select the provider of his/her choice. Additionally, SLP providers are required to assist customers with obtaining these services (89 Ill. Admin. Code 146.230(j)(2)). The PCP must include coordination and inclusion of services being delivered by an outside entity (89 Ill. Admin. Code 146.245(d)), as well as any services the customer chooses to decline (89 Ill. Admin. Code 146.250(e)(6)). Providers cannot maintain SLP services in combination with home health, home care, nursing home, hospital, residential care setting, congregate care setting or other type of residence or service agency (89 Ill. Admin. Code 146.215(i)). The MA verifies distinction of services annually.

Customers have the right and are strongly encouraged to participate in the development of their PCP (89 Ill. Admin. Code 146.245(d)) and 146.250(e)(16)). An authorized representative is involved at the request of the customer and for customers who are not able to be involved in the process due to their physical or cognitive status. Customers may also include others in the PCP development (89 Ill. Adm. Code 146.245(d)). Another right related to a customer's PCP is the option to refuse services, so long as others are not harmed by the refusal (89 Ill. Admin. Code 146.250(e)(6)). The SLP provider must explain the potential consequences to the customer and/or his authorized representative and include the refusal in the PCP.

The MA provides oversight of the PCP development process and delivery of services by reviewing fee for service customers' records annually. PCPs are among the documents examined for timeliness, thoroughness and accuracy, as well as signatures of the SLP provider RN and customer. A review of the customer's comprehensive assessment and their interview information is compared to the PCP to ensure all identified goals, preferences and needs are included. Additional documentation reviewed may include MD orders, nursing notes and medication orders and also customer interview. The PCP must identify desired outcomes, customer strengths and needs and steps to achieve desired outcomes, along with the person/staff/parties involved with the services and supports. Any services refused by the customer must also be noted. MA staff interviews a random representative sample of customers to verify their needs and preferences are being met.

Managed Care Organization (MCO):

MCO Care Coordinators do not provide direct waiver services. The MCOs' Care Coordinators complete an assessment to elicit comprehensive information from the customer. The assessment aids in the development of an overall PCP that includes community health services, along with the waiver services. The components in the assessment used by the MCOs include, but are not limited to cognitive/emotional, ADLs, IADLs, behavioral health, medication, living supports, environmental conditions and health care information. Customers and their authorized representative are involved in the development of the PCP. The SLP provider RN also provides a copy of the comprehensive assessment and suggested waiver services to the case manager for review with the customer and development of the PCP. Through the assessment and PCP process, the customers' goals and strengths and barriers to achieving these goals are identified. A copy of the PCP is given to the SLP provider.

Fee for Service and Managed Care:

Customers document their choice of provider at admission and annually thereafter. The MA's and External Quality Review Organization's annual record reviews includes the review of written verification by the customer regarding choice of provider.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a*

process in place to ensure:

- ☐ Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;
- ☐ An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;
- ☐ Direct oversight of the process or periodic evaluation by a state agency;
- ☐ Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and
- ☐ Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

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) The supports and information that are made available to the customer to direct and be actively engaged in the service plan development.

Fee for Service Process:

The person-centered plan (PCP) begins with an assessment and re-assessment conducted by the Supportive Living Program (SLP) provider's RN. Effective 7/1/2017, the SLP waiver became in full compliance with implementation of federal PCP requirements that encompasses a holistic approach.

Routine practice of the SLP provider RN includes asking the waiver customer who he/she would like to attend their PCP development session as an authorized representative. As the date and time is set for the PCP and discussion, the SLP provider RN is to make every accommodation possible to satisfy and include all persons identified by the customer. It is expected that all conversations between the SLP RN and the customer are customer-focused, constantly reinforcing that planning is a collaborative effort, enabling the waiver customer to lead the process to the best of his/her abilities and the outcome of the process is a PCP that is holistic, owned, is agreed to by the customer and is reflective of their needs, preferences, person-centered goals, safety, welfare and health status.

In addition, the language in these documents articulate the ability of the customer to include all persons chosen by the customer to be included at all informational gathering, assessment and reassessment meetings. Language states that meetings should occur at times and locations convenient to the customer, with the understanding that to fully assess the customers' needs, is the assessment needs to be completed in their home environment and that the waiver customer is in essence the driver of the PCP development. Language states that the conversation between the waiver customer and the SLP RN is to be goal centered.

As noted above, the holistic person-centered approach is designed for care coordination to encompass the comprehensive assessment of the customer's situation and circumstances related to all factors contributing to health, welfare, safety, community integration, quality of life, ability to live independently in the community and the customer's vision for his/her quality of life. The SLP provider RN utilizes the comprehensive assessment tool for this holistic approach. The process utilizes a tool that includes a review of the customer's physical, cognitive, psychological/emotional, and social well-being. The assessment covers education, occupation, customary routine, guardianship and living will, cognitive patterns, communication/hearing patterns, vision patterns, mood and behavior patterns, physical functioning, including activities of daily living (ADL) and instrumental activities of daily living (IADL), modes of locomotion, continence, disease diagnosis, medication, health conditions, including pain and falls, oral/nutritional status, skin condition, activity pursuit patterns and special treatments and procedures. Information collected in the assessment is used to help the SLP provider RN and the customer form the PCP. Risk factors, such as depression, alcohol and substance abuse, medications, caregivers, health, falls and behaviors, are identified and addressed throughout the domains of the assessment tool. SLP provider RNs discuss potential risks with the customer and work together to develop a PCP that will minimize or eliminate risk.

The comprehensive assessment prompts the SLP provider RN to ensure all areas of a holistic assessment are captured and includes what the customer hopes to achieve from the delivery of waiver services, as well as other available options. The PCP that emerges from this assessment and conversation is one that encompasses all customer needs, desires, goals and vision and links the customer with an array of options, not just those programs and services that are components of the waiver.

The PCP is the result of this comprehensive assessment and it captures the waiver customer's life goals and desires. It identifies supports, both waiver services and non-waiver services, to assist the customer in actualizing these goals and desires. The written documentation in the development of the PCP demonstrate that the customer exercised choice in the decision-making process. Once the PCP is developed by the SLP provider RN and the customer, it is signed by the customer, the SLP provider RN, and sent to all applicable providers for signature. A copy of the PCP is provided to the customer and all applicable providers listed on the PCP.

Customer rights for the SLP are included in the Ill. Admin. Code 146.250. Written notification of these rights are provided to customers and their authorized representative during the assessment and PCP process, initially at the time of admission and annually thereafter. Customer rights are also included in the resident contract signed by each customer or their authorized representative. The Medicaid Agency (MA) reviews all SLP provider resident contracts to verify customer rights are included.

Managed Care Organization (MCO):

The same processes of how an assessment and/or reassessment described above by the SLP provider nurse is expected of care coordination provided by the MCO. MCO Care Coordinators are expected to engage the customer and assure that he/she directs the process as much as possible by asking and encouraging at all levels of the assessment, reassessment and PCP processes. All accommodations are to be given to anyone he/she wishes to include in the discussions and meetings to develop a holistic PCP.

The MA strengthened language in the MCO contract with an amendment signed 12/18/19. The new language added PCP processes to the contract, including new requirements of informed customer choice (ensuring customers are able to make informed choices regarding services, supports and providers) and ensuring the PCP is written in a manner that is easily understood by the customer, including documentation that the setting where the customer resides is actually chosen by the customer. It also includes provisions that the HCBS Setting Rule is met when applicable.

The engagement and inclusion of the customer and those that he/she designates to be included in the process requires training and expertise by the MCO Care Coordinator. The MCO assessment tools and those given to them by the SLP provider RN prompts the Care Coordinators to ensure all areas of a holistic assessment are captured and that it reflects the goals, desires, and needs of the customer. The resulting PCP reflects what the customer hopes to achieve and meets the customer's expectations to the best of ability of available programs and services that include waiver and non-waiver programs and services. The PCP that emerges from this assessment and conversation is one that encompasses all customer needs, desires, goals, and vision and links the customer with the whole array of options, not just those programs and services that are components of the waiver.

The MCOs have assessment tools that contain components that are used to elicit and achieve holistic and comprehensive information from the customers to support a PCP. Components in the assessments include, but are not limited to cognitive/emotional ADLs, IADLs, behavioral health, medication, living supports, environmental conditions, and health care information. The MCOs review the annual comprehensive assessment completed by the SLP provider RN and use it when developing the service plan. In addition, the MCO Care Coordinator's assessment secures information that include the customer's strengths, needs, personal goals and desires, levels of functioning and risk. The customer's PCP is to be reviewed within 90 days of initial implementation of the service and reassessed as needed. MCOs are required to have the health risk assessment completed within 90 days of enrollment. A reassessment is to occur whenever the customer requests a reassessment, when there is a change in the customer's condition or, at a minimum annually. The Contract requires contact visits in the home no less than annually. All Care Coordinators are trained to discuss potential risks with the customer and work together to develop a PCP that will minimize or eliminate risk. Through the assessment and PCP process, the customer's goals and the strengths and barriers to achieving these goals are identified. Once the PCP is developed by the care coordinator and the customer, it is signed by the customer, the care coordinator, and sent to all providers. A copy of the PCP is provided to the customer and all providers listed on the PCP.

MCO Care Coordinators are also required to enable as much choice as possible with the MCOs offering options of providers to accommodate customer preferences and choice. MCOs must offer contracts to all willing and qualified certified SLP providers in the contracting area so long as the Provider agrees to the MCO's rate and adheres to the MCO's quality assurance requirements.

(b) The customer's authority to determine who is included in the process. (OA and MCO Processes)

The customer's right to determine who is included in the process is articulated in the SLP customer rights (89 Ill. Admin Code 146.250). This information is to be given to all customers at the time of assessment and reassessment. Also, as described in (a) above for both the SLP provider RNs and the MCO Care Coordinators, they routinely inquire and document the customer's authority to determine who is included in the process. This is documented in the PCP.

Appendix D: Participant-Centered Planning and Service Delivery

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

- d. **i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. 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 State is committed to implementation of a person-centered planning (PCP) process as required by 42 CFR 441.301 (c)(4)(5). Supportive Living Program (SLP) provider RNs and Managed Care Organization (MCO) Care Coordinators are required to include the customer in every aspect of the assessment and service plan development, including providing the customer and his/her representative with the opportunity to lead the planning process.

The SLP provider RN or MCO Care Coordinator contacts the customer or authorized representative, by phone or in person, prior to the scheduling of the assessment. Assessments are generally conducted in the customer's residence. The SLP provider RN and MCO Care Coordinator schedule the visit around the customer and other parties that the customer wishes to have included.

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

Fee for Service Process:

The SLP provider RN conducts a face-to-face comprehensive assessment of the customer. The PCP template contains a "what is important to me", "desired outcome" and "strengths" sections where the customer expresses his/her goals, preferences, interests and choices, which include those related to service needs, overall life goals or desires and their expectations for care. Goals are holistic and are not restricted to only needs that will be addressed by waiver services. For example, if the waiver customer voices a desire to attend a house of worship or to go to lectures at the library, these should appear under goals and be articulated in the PCP.

Customers and anyone they wish to include are to have an active role in the development of the PCP. This includes choosing services and service providers. The face-to-face assessment is conducted in the customer's residence as this is most convenient for the customer and enables the SLP provider RN to see the customer function in their home environment. Changes to location are to meet the customer's needs and are not for the convenience of SLP provider staff.

In terms of timing, an initial plan is required within 24 hours of admission (89 Ill. Adm. Code 146.245(b), "The SLP 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 of the PCP. The PCP is due within 7-21 days of admission and includes a more in-depth discussion with the customer, a comprehensive assessment and an observation period. Each PCP is individualized for the customer. The PCP is reviewed and updated at the request of the customer, in conjunction with required evaluations and as dictated by changes in a customer's condition, needs or preferences. The 89 Ill. Adm. Code 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". PCPs are developed at a time and location convenient for the customer, authorized representative, and others the customer chooses to involve.

Managed Care Organization (MCO) Process:

Similarly, once waiver eligibility is established, the PCP is developed by the MCO Care Coordinator in collaboration with the customer and/or their representative following the same expectations as those set by the SLP provider RN. The MA has set the same expectations regarding setting of the assessments and reassessments at the convenience of the customer. At the time of the assessment and PCP development process the customer is encouraged to include the person(s) of their choosing to attend a face-to-face visit with their assigned Care Coordinator. The date and time of this face-to-face visit is collaborated and based on the customer's preference. The face-to-face assessment visits are conducted in the customer's residence as this is most convenient to the customer and leads to a more accurate assessment of the customer. Changes to location are to meet the customer's needs and are not for the convenience of MCO staff.

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

Fee for Service Process:

In (a) above, the process in all assessments is to have the customer articulate his/her needs, goals, and desires. Using this as a basis for a holistic approach to care coordination, the assessment of the customer's situation and

circumstances identifies all factors contributing to quality of life and the customer's ability to live independently in the community. The SLP utilizes the following assessments completed by SLP provider staff. SLP provider RNs are required to encourage the customer to direct the assessment as much as possible, to discuss potential risks, and work together to develop a PCP that will minimize or mitigate/eliminate the risk.

Standardized Interview

An interview administered by the SLP provider that is geared toward the customer's service needs must be done at or before the time of move-in (89 Ill. Admin. Code 146.245(a), "The SLF shall conduct a standardized interview geared toward the resident's service needs at or before the time of occupancy").

Initial Resident Assessment

An initial assessment of the customer and an initial plan are completed within 24 hours after admission (89 Ill. Admin. Code 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 customer, authorized representative and whomever the customer wishes to include, along with medical records. The comprehensive assessment 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 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 customer's needs and preferences.

Comprehensive Assessment

A comprehensive assessment tool required by the Medicaid Agency (MA) is completed within 7-14 days after admission, annually and in response to a change in condition. The comprehensive assessment is designed to capture the customer's strengths, needs, preferences, health status and risk factors. This tool assesses a customer's cognitive, communication, and vision patterns, mood and behavior patterns, physical functioning, activities of daily living (ADL) and instrumental activities of daily living (IADL), 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 customer, authorized representative and others the customer chooses to involve. SLP staff observation and the review of medical records are also included. Information documented in the assessment and information received from the customer are used to develop the PCP. Completion of the assessment is the responsibility of the SLP provider RN.

Quarterly Evaluation

The quarterly evaluation is completed within 92 days from the previous assessment. This evaluation must include information regarding the customer's current status (89 Ill. Admin. Code 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 assessment and the development of the PCP, the customer and his/her authorized representative participate in this evaluation. The evaluation form must be signed by the SLP provider nurse and the customer or authorized 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 PCP. The quarterly evaluation is the responsibility of the SLP provider RN.

Dementia Program Assessments:

The SLP dementia program requires additional assessments specific to persons with cognition problems. These assessments are completed by the SLP provider RN. If a dementia program customer is enrolled in a Managed Care Organization (MCO), copies of the assessment are provided to the MCO Care Coordinator for use with the development of the PCP.

Elopement Risk Assessment

An elopement risk assessment designated by the MA must be completed for dementia program customers prior to admission and quarterly thereafter. The purpose of the assessment is to determine if the customer requires a safety intervention of delayed egress. This assessment must be completed by an RN. The customer's need for delayed egress must be included on the PCP. Customers without the need for delayed egress may receive services.

Kitchen Appliance Assessment

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

MOCA or SLUMS Assessment

The Montreal Cognitive Assessment or the St. Louis University Mental Status assessment must be completed within 7-14 days of admission. This assessment must be completed by an RN.

MCO Process:

The MCOs have similar comprehensive assessment tools that contain components that are used to elicit a wide range of information from the customers and their representatives to support PCP development. These components in the assessments include, but are not limited to cognitive/emotional, ADLs, IADLs, behavioral health, medication, living supports, environmental conditions, and health care information. The assessment secures information including the customer strengths, needs, levels of functioning, and risk factors. Additionally, the MCO Care Coordinator reviews the comprehensive assessment completed by the SLP provider RN. The MCOs also use the MCO claims data and real-time customer data to identify a customer's risk level and to help in the creation of the PCP. MCOs also use referrals, transition information, service authorizations, alerts, grievance system, memos, and other assessment tools. These tools are both internal and adopted by the MA, as well as from families, caregivers, providers, community organizations, and MCO personnel. Through the assessment and PCP processes, the customer's goals and the strengths and barriers to achieving these goals are identified. The MCO Care Coordinators are trained to look at the individual and approach the customer to directing the process.

The MCO contract specifies expectations for waiver customers, including content of and purposes for the PCP. As part of its work on behalf of HFS, the External Quality Review Organization (EQRO) reviews assessments as part of its pre-implementation record review, onsite post-implementation record review, as well as in quarterly record reviews, to ensure the assessments meet contractual requirements.

c) Informing customer of services available under the waiver:

Fee for Service Process:

The resident contract is required to include information regarding the services available to customers under the waiver. SLP providers are required to submit to the MA for approval, prior to use, copies of every type of resident contract, thus ensuring waiver services are included (89 Ill. Admin. Code 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 customer or authorized representative at or prior to occupancy.

The SLP provider RN discusses with the customer the array of services, regardless of funding sources, which are available to them and for which they are eligible. The array of services also includes the customer's goals that may not be met by a waiver or other formal services. It is the SLP provider RN's responsibility to explain all service options to the customer, including, but not limited to waiver services. Customers review and sign the PCP and initial that they choose to receive services from the SLP provider or would like to receive referral information for other programs.

MCO Process:

The MCO Care Coordinator provides "customer health education", including how to access benefits and supports, for example, waiver services, at the initial face-to-face visit. The Care Coordinators are trained to engage and encourage the customer to take the lead in PCP development. They also identify services that are available through other state and federal agencies, local entities, and charitable organizations that may assist the customer in attaining their goals and desires. The PCP that emerges from this conversation is to reflect waiver services and informal services.

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

Fee for Service Process:

The SLP comprehensive resident assessment is designed to capture the customer's strengths, needs, preferences, health status and risk factors. This tool assesses a customer's cognitive, communication, and vision patterns, mood

and behavior patterns, physical functioning, activities of daily living (ADL) and instrumental activities of daily living (IADL), 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 customer, authorized representative and others the customer chooses to involve. SLP staff observation and the review of medical records are also included. Information documented in the assessment and information received from the customer are used to develop the PCP. Completion of the assessment is the responsibility of the SLP provider RN. Any area of need identified on the assessment or expressed by the customer must be included in the PCP. Customers must sign the PCP and initial they choose to receive services from SLP provider or initial that they request to receive referral information for other programs. All providers responsible for the implementation of the person-centered plan must sign and receive a copy of the plan.

MCO Process:

Comprehensive assessments are developed by the MCOs. The MCO contract specifies expectations for waiver customers, including content of and purposes for Customer Care Plans and HCBS Waiver PCPs (for customers receiving HCBS Waiver services).

After the comprehensive assessment has been completed by the MCO, and the array of services have been presented to and discussed with the customer, the MCO's Care Coordinator, the customer and/or their representative(s) formulate an individualized PCP that addresses their goals, strengths and barriers/risks in consideration of these goals, and the mutually agreed upon activities for achievement of these goals. The outcome is the PCP. As this is customer-centric, personal preferences are integral to the development of the PCP, such as cultural preferences, living arrangements, and provider preferences for language and time of services. The PCP includes the type, amount, frequency, and duration of waiver services, and includes services and supports not covered under the waiver, all related to the needs and preferences expressed by the customer. The strength of the MCO model is the actual care coordination of healthcare needs and long-term services and supports. MCOs develop a holistic PCP and are responsible for monitoring its implementation, along with the customer. As part of its work on behalf of the MA, the EQRO reviews assessments as part of its pre-implementation record review, onsite post-implementation record review as well as in quarterly record reviews to make sure the assessments meet contractual requirements. Customers must sign the PCP agreeing to receive services from SLP provider and acknowledge that they may request to receive referral information for other programs. All providers responsible for the implementation of the person-centered plan must sign and receive a copy of the plan.

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

Fee for Service Process:

The PCP must include the coordination of waiver and non-waiver services being delivered to a customer by the SLP provider or an outside provider (89 Ill. Admin. Code 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 assessment and by communication at any time between the customer and SLP provider. Whenever and however the information is learned, it must be incorporated into the PCP. The SLP provider's RN is responsible for ensuring that the customer's PCP is implemented appropriately, including coordination with outside entities.

MCO Process:

Services are coordinated by the customer's assigned MCO Care Coordinator, who is responsible for the identification, authorization, and assignment to the responsible service provider in coordination with and direction from the customer and/or their representative. MCO Care Coordinators are expected to offer information on non-waiver services to the customer and make referrals as appropriate on behalf of the customer. All non-waiver services should be included on the PCP created by the MCO Care Coordinator in conjunction with the customer.

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

Fee for Service Process:

The PCP must identify who will assist and support the customer with achieving their desired outcomes for waiver and

non-waiver services (89 Ill. Admin. Code 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 PCP, the appropriate individuals are notified regarding their responsibilities in providing specific services and support to the customer. The PCP also includes the customer's strengths that will assist with achieving desired outcomes and the steps to achieve they have identified. The SLP provider's RN is responsible for assigning responsibilities to implement the PCP and also to monitor. PCPs are reviewed at least quarterly, or more often if a change in condition occurs or at the customer's requests.

MCO Process:

The MCO Care Coordinator is responsible for the execution of the PCP, which includes monitoring the provision of waiver services and risk mitigation strategies. The customer's role is clearly defined in the PCP, and the customer is responsible for actively participating and providing feedback.

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

Fee for Service Process:

Customers may request a review of their PCP at any time. At a minimum, the PCP must be reviewed quarterly. If a customer experiences a change in condition, needs or preferences, the PCP must be updated at that time (89 Ill. Admin. Code 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"). PCPs must be completed at least annually.

The customer is in the center of the PCP process. The SLP provider RN completes a comprehensive resident assessment to identify the customer's strengths, needs, formal and informal supports based on information provided by the customer or authorized representative. The customers have an active role in choosing the types of services and service providers to meet those needs. The SLP provider's RN obtains the customer's signature of agreement on the PCP and the customer initials verifying they choose to receive services from the SLP provider or that they request referral information for other programs. All providers responsible for the implementation of the person-centered plan must sign and receive a copy of the plan.

MCO Process:

Administrative Rules require that customers receive a new assessment at least annually; whenever requested by the customer/authorized representative; or whenever the customer may have experienced a change in his or her needs that indicate the need for a reassessment to meet their needs. During assessments, the MCOs Care Coordinator educates the customer to call the MCO Care Coordinator to request a change in the PCP if the customer's situation or needs change in-between assessments. The customer is educated to notify the MCO Care Coordinator any time there is a change in their living or medical situation that may affect their need for services. PCPs can be created or adjusted in-between assessments to meet the customer's immediate needs. Whenever there is a change in level of service needs or functioning (for example, hospitalization significantly impacting the customer's level of functioning), a new assessment is to be completed and additional services provided as needed.

The customer is in the center of the PCP process. The MCO Care Coordinator completes a comprehensive assessment to identify the customer's strengths, needs, formal and informal supports based on information provided by the customer or representative. The customers have an active role in choosing the types of services and service providers to meet those needs. The MCO Care Coordinator obtains the customer's signature of agreement on the PCP and offers the customer a choice of providers to fulfill the services. All providers responsible for the implementation of the person-centered service plan must sign and receive a copy of the plan.

For reassessments, MCOs analyze reports and data on a monthly basis to identify risk level changes for their customers. High risk customers have PCPs updated every 30 days and moderate risk members have PCPs updated annually. At a minimum, MCOs shall conduct a health risk reassessment annually for every member with a PCP. All HCBS customers, including SLP Waiver customers, have a PCP.

h) how the participant engages in and/or directs the planning process:

Customers have the right and are strongly encouraged to participate in the development of their PCP (89 Ill. Admin.

Code 146.245(d)) and 146.250(e)(16)). An authorized representative is involved at the request of the customer and for customers who are not able to be involved in the process due to their physical or cognitive status. Customers may also include others in the PCP development (89 Ill. Adm. Code 146.245(d)).

The PCP process must occur at a time and location that is convenient for the customer. The customer remains at the center of all planning activities. PCP involves asking meaningful questions to gain a clear understanding of the customer, including their needs, goals, and strengths. Both the planning process and the written plan must be communicated in language that is understandable to the resident.

The PCP must accurately reflect the individual customer's interests, preferences, goals, needs, and strengths. Furthermore, if the customer's needs, preferences, or goals change, the PCP will be updated at least quarterly to ensure it remains current and responsive to those changes.

CONTINUED IN MAIN B OPTIONAL

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

- ☒ The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- ☒ For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:
 - ☒ A specific and individualized assessed need for the modification.
 - ☒ Positive interventions and supports used prior to any modifications to the person-centered service plan.
 - ☒ Less intrusive methods of meeting the need that have been tried but did not work.
 - ☒ A clear description of the condition that is directly proportionate to the specific assessed need.
 - ☒ Regular collection and review of data to measure the ongoing effectiveness of the modification.
 - ☒ Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
 - ☒ Informed consent of the individual.
 - ☒ An assurance that interventions and supports will cause no harm to the individual.

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.

SLP provider RNs assess for customer needs, evaluate current customer risks and work with the customer to identify the resources and strategies to mitigate these risks through the linkage and delivery of services ultimately to prevent institutionalization and be successful in community residency. For example, if the customer is at nutritional risk, consultation with a licensed dietician may be part of the of PCP to mitigate this risk.

The comprehensive assessment tool requires the SLP provider RN and customer to discuss other factors or services beyond waiver services that may help mitigate risk. This may include behavioral health services to address depression, anxiety and abuse of alcohol or other substances including illegal substances and medications; caregivers; physical health; mitigation to prevent occurrences and risks of falls are explored and addressed.

Additionally, per 89 Ill. Admin. Code 146.295, SLP providers are responsible to have emergency policies. Customers are oriented to the emergency plan and staff receives training at the time of hire and annually. The policies must address various emergency scenarios, including fire, tornado, power outage and flooding. Additionally, fire and tornado drills are required.

MCO Process:

For customers enrolled in an MCO, the assessment for potential risk is included in the PCP development process. The MCO Care Coordinator at the MCO is expected to incorporate and utilize the same strategies as described above in the development of the PCP. In addition, the MCOs use predictive modeling reports and other surveillance data, including claims data to assess risk and identify risk level changes.

The MCO Care Coordinator completes a comprehensive assessment and care plan for every customer. This process includes identification of the customer's cognitive/emotional functioning, behavioral health, medication, living supports, environmental conditions, ADLS, IADLS and health information. This process identifies risks that could encompass such domains as the behavioral health of the customer including depression, anxiety and the abuse of alcohol or other substances including illegal substances and medications; providing a crisis safety plan for a member with behavioral health conditions; role of caregivers; physical health; occurrences and risks of falls. These are explored and addressed as they may increase and serve as barriers to the customer's ability to live as safely and independently as possible. All risks are identified and discussed while developing the PCP. Through service planning interventions, identified risk(s) are mitigated and barriers are addressed with interventions which are mutually agreed upon by the customer and the 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.

Managed Care Organization (MCO) and Fee for Service Process:

Information of available providers is available on the Medicaid Agency's (MA) website under the Supportive Living Program (SLP) page for customers and their families to review available SLP providers and services. SLP providers may also have their own brochures, advertising material and marketing plans.

Additionally, The Illinois Department of Human Services (DHS), Family and Community Resource Center caseworkers, who are responsible for accepting Medicaid applications and determining eligibility, may make referrals. The Illinois Department on Aging's Care Coordination Units and DHS, Division of Rehabilitation Services staff that perform initial level of care assessments for customers in need of waiver services may provide information regarding the SLP, too. 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 customers and supply information regarding providers, services and programs.

Customers and families are encouraged to visit SLP provider settings before agreeing to services. Customers/authorized representatives identify the provider chosen and sign the resident contract to verify the provider selected. By selecting a SLP provider and executing a resident contract, the customer accepts the services that the provider is obligated to provide under the SLP waiver. A customer 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 assessment service planning meeting and referral contact information is provided to the customer, if requested.

MCO Process:

For customers enrolled in an MCO, the MCO Care Coordinator assists the customer in obtaining information and selecting from among qualified certified SLP providers of the waiver services in the PCP. The State requires that freedom of choice be afforded to all customers in the waiver.

The MCO Care Coordinators meet with the customers to discuss their goals and desires and develop the PCP. It is the MCOs Care Coordinator's role to provide information about the available services and service providers to each customer, and to answer any questions that arise. The MA notifies all MCOs and MCO Care Coordinators of all certified SLP providers that provide services in specific geographic service areas. The SLP provider and the MCO work together to establish a contract between their agencies so waiver services can be provided to waiver MCO customers. The MCO Care Coordinator will assist the customer through the provider network supplying provider information relevant to the services selected by the customer on their PCP and available in the customer's service area. If the customer has no preference of a provider agency, then the MCO Care Coordinators are required to utilize a rotating service provider list. This list includes all service providers in the geographic service area of the customer. Customers always have first choice on the providers they select to meet their needs. MCO Care Coordinators support the customer in selecting a provider to meet their needs if the customer does not have a preferred provider identified. The MCO maintains a current list of qualified and contracted SLP service providers which are made available to customers upon request. The customer is also educated that the MCO's provider list is available on the MCO's website.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

The Supportive Living Program (SLP) provider and the Managed Care Organizations (MCO) have day-to-day responsibility for completion and approval of PCPs; however, the MA, through its Quality Improvement System, reviews PCPs through a sample process as described below.

Fee for Service Process:

The MA conducts annual on-site certification reviews at all SLP providers. This includes a review of fee for service customers' PCPs to assess compliance with the PCP performance measures. SLP providers are required to remediate findings within required timelines. MA staff complete unannounced follow-up reviews to verify remediation. The MA monitors both individual and systemic remediation. The MA has quarterly meetings with the SLP waiver staff during which quality improvement activities are reviewed and remediation approaches and trends are discussed.

MCO Process:

For the MCOs, the MA selects a statistically valid sample for conducting onsite record reviews to assure compliance with federal assurances. The MA uses a proportionate sampling methodology with a 95% confidence level and a +/- 5% margin of error.

Once the MA selects the sample, it is provided to the MA's External Quality Review Organization (EQRO), the entity responsible for monitoring the MCOs. The MA and the EQRO determines a review schedule, based on the sample and performs onsite record reviews to assess compliance with the PCP performance measures. For the MCOs, the EQRO sends a report of findings to the MA and the MCOs. The MCOs are required to remediate findings within required timelines, and report remediation activities to the MA, at least quarterly. The MCOs report on both individual and systemic remediation. The MA has quarterly meetings with the MCOs during which quality improvement activities are reviewed and remediation approaches and trends are discussed.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, 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:

Fee for Service:

Person-centered plans (PCP) are reviewed quarterly.

Managed Care:

PCPs are reviewed every twelve months or more frequently when necessary.

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 customers enrolled in a Managed Care Organization (MCO), the MCO is responsible for maintenance of the person-centered plan forms for a minimum of three (3) years.

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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The State is committed to the adherence to the HCBS settings requirements as required by 42 CFR 441.301 (c)(4)-(5).

Fee for Service Process:

The Supportive Living Program (SLP) provider RN is responsible for monitoring the implementation of the person-centered plan (PCP) and the customer's health, safety and welfare.

a) SLP provider RNs and customers develop the PCP together during the initial assessment and at each reassessment the PCP is reviewed and adjusted as needed. Customers are provided with the opportunity to lead the PCP process. The MA administrative rules require that customers receive a new assessment at least annually and when there is a change.

The required comprehensive assessment addresses all aspects of customer function and supports. The SLP provider nurse identifies services needed and makes the appropriate referrals, as agreed upon by the customer during the PCP process. Referrals are made for a variety of services including those outside the services offered in the SLP waiver. Examples of additional services include transportation and home health services.

b) SLP provider RNs monitor the provision of services through customer contact and required annual and quarterly assessments.

The customer or authorized representative can request a meeting with the SLP RN at any time. When problems are detected, PCPs can then be revised or new a plan can be implemented. The SLP provider RN monitors any changes to help ensure problems are adequately addressed.

c) SLP provider RNs are required to meet face to face with waiver customers quarterly, and more often as needed.

It is the customer's responsibility to notify the SLP provider RN of any change in status or to request a change to the PCP. Customers can request a change to the PCP at any time.

As part of the MA's monitoring process, comprehensive record reviews are conducted annually for 100% of new fee for service customers and a random representative sample of continuous residents. This monitoring involves an in-depth record review that includes, but is not limited to: the PCP, comprehensive assessment, quarterly evaluations, medication management service records, incident reports and physician orders. MA staff also meets in person with customers and conducts a standardized interview that includes questions regarding services received and choices and preferences. The health and safety of customers is monitored by confirming all required and preferred services are included in the PCP, that risks are identified and mitigated, customers' physicians are notified of changes in condition and that required MA reporting takes place as required by administrative rule.

MA staff ensures customers' comprehensive assessments, which are used to assist with the development of the PCP, are completed within required timeframes, accurately reflect customer's needs, strengths, health conditions and service provision and that any significant changes in condition are documented.

Managed Care Organization (MCO) Process

For customers enrolled in a MCO, the MCO Care Coordinator is responsible for monitoring PCP implementation, including whether services and supports meet the customer's needs.

For the MCOs, the primary avenue to monitoring the customer's needs and PCP is the completion of the comprehensive assessment with the customer. The MCO Care Coordinator and the customer work collaboratively during the initial assessment and at each subsequent reassessment on the PCP process. The MCO Care Coordinator is responsible for monitoring the implementation of the PCP, the availability and effectiveness of identified services and supports, and the customer's overall health and welfare.

The MCO Care Coordinator works with the customer to identify the agreed upon services to include in the PCP and coordinates the service delivery process based on the customer's needs. MCO Care Coordinators also identify services, supports, or activity outside of the waiver benefit that may support the customer's PCP. In addition to being completed at the initial assessment and reassessment visits, the PCP is also reviewed in-between assessments if there is a change in service needs or a change in customer's health condition.

- b. Monitoring Safeguard.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except,

at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

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:

D1: Number and percent of FFS and MCO customers' person-centered plans (PCP) that address all personal goals. Numerator: Number of FFS and MCO customers' PCPs that address all personal goals. Denominator: Total number of FFS and MCO customers' PCPs reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

D2: Number and percent of FFS and MCO customers' person-centered plans (PCP) that address all needs identified in the assessment. Numerator: Number of FFS and MCO customers' PCPs that address all needs identified by the assessment. Denominator: Total number of FFS and MCO customers' PCPs reviewed.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

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

		95% confidence level with a +/-5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

D3: Number and percent of FFS and MCO customers' person-centered plans (PCP) that address all health and safety risk factors identified by the assessment.

Numerator: Number of FFS and MCO customers' PCPs that address all customer health and safety risk factors identified by the assessment. **Denominator:** Total number of FFS and MCO customers' PCPs reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

- b. *Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.*

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:

D4: Number and percent of FFS customers who have a person-centered plan (PCP) completed within in 7 days of their comprehensive assessment. Numerator: Number of FFS customers who have a PCP completed within 7 days of their comprehensive assessment. Denominator: Total number of FFS customers' PCPs reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Agency		
☐ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with +/-5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measure:

D5: Number and percent of MCO customers contacted by their MCO Care Coordinator annually in an effort to monitor service provision and address potential gaps in service delivery. N: Number of MCO customers contacted by their MCO Care Coordinator annually in an effort to monitor service provision and address potential gaps in service delivery. D: Total number of MCO customers' 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):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with +/-5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:

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

Data Aggregation and Analysis:

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

- c. **Sub-assurance: 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:

D6: Number and percent of FFS and MCO customers who have their PCP updated every 12 months. Numerator: Number of FFS and MCO customers who have their PCP updated every 12 months. Denominator: Total number of FFS and MCO customers with PCPs due during the period reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:

D7: Number and percent of FFS and MCO customers that received updates to the Person Centered Plan (PCP) when a change in need was identified. Numerator: Number of FFS and MCO customers that received updates to PCP when a change in need was identified. **Denominator:** Total number of FFS and MCO customers PCPs where a change in need was identified that were reviewed.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

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

		95% level of confidence with +/- 5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

d. 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:

D8: Number and percent of FFS and MCO customers who received services in the type, scope, amount, duration, and frequency as specified in the PCP. Numerator: Number of FFS and MCO customers who received services in the type, scope, amount, duration, and frequency as specified in the PCP. Denominator: Total number of FFS and MCO customers reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Interview, Record Review, EQRO

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with +/-5% margin of error
☐ Other	☒ Annually	☐ Stratified

Specify: 		Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

e. **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:

D9: Number and percent of FFS and MCO customer records that indicate choice was offered between waiver services and institutional care; and between/among services and providers. N: Number of FFS and MCO customer records that indicate choice was offered between waiver services and institutional care; and between/among services and providers. D: Total number of FFS and MCO customer 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):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with +/-5% margin of error.
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ 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):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

D1: If person-centered plans (PCP) do not address required items, the Medicaid Agency (MA) will require the PCPs be corrected.

D2: If PCPs do not address required items, the MA will require the PCPs be corrected.

D3: If PCPs do not address required items, the MA will require the PCPs be corrected.

D4: MA will require customer's PCP to be completed.

D5: MA will require customer be contacted.

D6: If PCPs are untimely, the MA will require completion of overdue PCPs.

D7: If PCPs are not updated when there is documentation that a customer's needs changed, the MA will require an update.

D8: If a customer does not receive services as specified in the PCP, the MA/MCO will determine if a correction or adjustment of the PCP, services authorized, or services vouchered is needed. If not, services will be implemented as authorized. The MA/MCO may also provide training to the MCO Care Coordinator. If the issue appears to be fraudulent, it will be reported by the MA.

D9: The MA/MCO will assure that choice was provided as shown by the correction of documentation to indicate customer choice.

Summary of remediation processes for all performance measures:

Remediation for FFS customers will follow the 89 Ill. Adm. Code 146.280 for non-compliance action. The Supportive Living Program (SLP) provider is presented the findings in writing. A plan of correction must be submitted to the MA within fourteen days of receiving the findings of non-compliance. The plan must be implemented within thirty days. MA 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, MA staff would assist customers with relocation, including transfer to another SLP residence. For customers enrolled in a MCO, care coordinators may receive training and remediation must occur within 60 days.

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>):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☒ Other Specify: MCO	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

☒ No

☐ Yes

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

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.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

Appendix E: Participant Direction of Services

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

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

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

Appendix E: Participant Direction of Services

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

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 customers 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 customers and potential customers who are not given the choice of Supportive Living Program (SLP) services as an alternative to nursing facility services. This can occur as a result of not being determined eligible for the SLP or receiving a notice of involuntary discharge from a SLP provider.

Customers or their designated representative are informed of the appeal process in writing at the time of the denial of services. Furthermore, resident contracts for customers with SLP providers must contain information regarding the involuntary discharge process, including the customer's right to appeal (89 Ill. Adm. Code 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 Medicaid Agency (MA), which ensures appeal information is included

Eligibility

Prior to admission, all potential customers, must undergo an initial level of care assessment and meet a minimum score. If a potential customer disagrees with the preadmission screening results, he/she may submit a request for an appeal to the MA, Department on Aging contracted Care Coordination Unit or Department of Human Services, Division of Rehabilitation Services, depending on which entity completed the initial level of care assessment. Appeal information is provided to the potential customer at the time of the initial assessment.

Annual level of care determinations are performed for each customer by the MA. If a customer is found to no longer meet the required minimum level of care, a case action notice form is issued by the MA. This form contains the reason(s) why the customer is no longer eligible for the program. Additionally, a notice of appeal form is supplied to the customer that contains a phone number for the MA to request assistance with filing the appeal. The MA also contacts the long term care ombudsman to assist the customer with filing an appeal. The MA is responsible for maintaining the case action notice form and also reviews appeals.

Additional assessments

If a prospective customer or his/her representative disagrees with a mental health or developmental disability review completed by a qualified Department of Human Services (DHS) screening agent or contractor of the MA 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. If the prospective customer or his/her representative does not agree with the response, the decision may be appealed to the MA. Information regarding the appeal process is provided in writing to the prospective customer.

Involuntary Discharge

SLP providers must provide written involuntary discharge notices to customers (89 Ill. Adm. Code 146.255). A 30-day notice is required, except in instances when a customer is a danger to themselves or others, or if the customer's physical or mental health care needs require discharge sooner. A 30-day written notice of discharge can be issued by a SLP provider when: a customer breaches the resident contract, the provider has had its certification terminated, suspended, or not renewed by the MA, the provider cannot meet the customer's needs with the required support services or when a customer 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 customer 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 setting.

The notice of involuntary discharge form must be completed by the SLP provider and given to the customer. The form includes the reason(s) for discharge, information for filing an appeal and a phone number for the MA to request assistance with filing the appeal (89 Ill. Adm. Code 146.255). The SLP provider is required to supply a self addressed, stamped envelope with the appeal form (89 Ill. Adm Code 146.255). If an appeal is filed, the discharge is stayed until the hearing decision is rendered. The customer may remain at the SLP residence until the 10th day after the receipt of the MA's hearing decision, unless the customer is a danger to him/herself or others. The SLP provider is responsible for maintaining the notice of involuntary discharge form and right to appeal information. The MA is responsible for conducting the hearing.

Fair Hearing by the MA

The MA's fair hearings process is the same for all customers, whether FFS or enrolled in an MCO. The MA is the final level of Appeal. An MA Hearing Officer conducts the formal hearing. At the hearing, the customer can present evidence on his/her behalf to dispute the adverse action. The customer may choose to be represented by legal counsel or another person the customer appoints. The decision of the formal hearing is made by the Medicaid Director and is final and can only be appealed through the circuit court system.

Customers who file an appeal within 10 days of notice of the adverse action will continue to receive services through the appeal

process (89 Ill. Adm. Code 146.255). Fair hearing documents, including notices of adverse actions and requests for a Fair Hearing, are maintained by MA.

Example of when a customer may request a fair hearing:

- Following refusal by the MA, SLP provider or MCO to provide any service it is authorized to provide,
- Modification of any service currently provided to the customer by the SLP provider or MCO, termination of a service or case closure, unless agreed to by the customer,
- Determination that a customer is ineligible for services.

Advocacy

The LTC Ombudsman Program (LTCOP) provides services to FFS and MCO customers receiving HCBS. The LTCOP was initially designed to protect and promote the rights and quality of life for customers who reside in LTC facilities. LTCOP coverage includes seniors aged 60 and older, and disabled adults between the ages of 18-59. The target population includes customers of the Medicare/Medicaid Alignment Initiative, in addition to customers receiving Medicaid waiver services. A Home Care Ombudsman may assist a customer who has requested assistance with grievances and appeals and may represent a customer in a fair hearing. In order to do this, the customer must provide consent by completing the Authorized Representative Form.

Due to character limits, this response is continued on Main Section's Optional Page.

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**
 - **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.

Do not complete this item.

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

For Fee-for-Service (FSS) customers, the Medicaid Agency (MA), operates the grievance and complaint system.

For participants enrolled in an managed care organization (MCO), the MCOs establish and maintain procedures for reviewing grievances registered by customers.

Each MCO is required to establish and maintain a procedure for reviewing grievances (any expression of dissatisfaction about any matter other than an action) registered by customers.

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

(a) the types of grievances/complaints that participants may register;

A grievance may be submitted for any action or inaction taken by a provider or state staff person. Grievances may include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the customer's rights regardless of whether remedial action is requested. This includes a grievance related to the Medicaid Agency (MA)'s, managed care organization (MCO)'s, or a provider's performance of planning, developing, implementing and reviewing the person-centered plan (PCP), home and community-based settings, settings that are not home and community-based, home and community-based settings compliance and transition.

Customers are informed that filing a grievance or complaint is not a prerequisite or substitute for an appeal and fair hearing. The MA procedures do not require customers to file an informal grievance prior to exercising their right to appeal. An appeal can be requested by a customer/authorized representative for any action/inaction taken by a SLP provider or the MA. A customer does not need to file a grievance before starting this process.

(b) the process and timelines for addressing grievances/complaints;

Complaints about Supportive Living Program (SLP) providers may be registered by anyone. Complaints are received from customers, friends and family, SLP provider employees and State Long Term Care ombudsman. Individuals may register a complaint anonymously. The MA receives complaints directly via a toll-free telephone number, e-mail, written correspondence and in-person during on-site visits by MA staff. A complaint may be filed at any time and does not have to be filed within a set number of days since the grievance event occurred. Complaints investigated by the MA must be relevant to waiver services and program requirements. Additionally, all complaints are kept confidential.

MA staff are trained to distinguish the difference between an informal grievance or complaint versus an appeal. If a customer or representative calls the MA with what is actually an appeal, MA staff offers to assist with filing an appeal. The MA also provides customers the opportunity to participate in an information resolution conference to resolve issues that do not rise to the level of a formal complaint or formal hearing or can be resolved prior to the hearing.

The MA maintains and monitors the complaint database on an ongoing basis. The complaint database includes, at a minimum, the customer's name, date complaint received, reason for complaint, date(s) of review, resolution, and date of resolution. Data is reviewed and analyzed by the MA to identify trends or issues requiring further investigation. Any trends and/or patterns determined from data analysis will be addressed by the MA as needed or during quarterly Quality Management Meetings. The MA can provide assistance to a customer in filing a grievance if requested. The MA staff will assist a customer with filing a grievance when the customer contacts the hotline or email.

For fee-for-service customers, the MA will send the customer a written letter of acknowledgement. The MA will resolve grievances as quickly as possible but within 90 calendar days of the receipt of the grievance. The grievance process may be extended by up to 14 calendar days if requested by the customer or if the MA determines and documents a need for additional information that is in the best interest of the customer. If the timeline is extended, the customer will be notified promptly, and the MA will send written notification within 2 calendar days of the decision to extend the timeframe. When a resolution is determined, the customer will be notified of the decision in writing.

For the MCO populations, grievances and complaints are handled through the MCO. A customer may submit their grievance orally or in writing, using any method of communication they prefer. An explanation of how to file a grievance is included in all customer handbooks. Grievances may include the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the customer's rights regardless of whether remedial action is requested. The MCO must acknowledge the receipt of the grievance within 48 hours. The MCO has no longer than 90 days to resolve the grievance; the MCO may inform the customer of their decision verbally or in writing.

(c) the mechanisms that are used to resolve grievances/complaints.

When the MA receives a complaint involving a possible administrative rule violation, a SLP Complaint Referral Notice form is completed and forwarded to regional MA staff. This form contains specifics about the complaint, including customers and staff involved, the nature of the complaint and date(s) of incident(s). For confidentiality, customer and staff names are not identified on the form itself but are provided to regional MA staff on an attached key. MA staff must

begin an investigation 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).

When the MA receives a complaint involving a possible administrative rule violation, a SLP Complaint Referral Notice form is completed and forwarded to regional MA within seven days of receipt of the complaint. If a complaint involves immediate health and safety issues, regional staff are directed to investigate sooner. MA employees are also mandated reporters. This status requires them to report suspected abuse or neglect of participants to local law enforcement. Depending upon the nature of the complaint, investigations may be performed on-site at the SLP setting, as a desk audit, or as a combination. Investigations may involve interviews with customers and staff, review of customer and employee records, a tour of the SLP setting and observation of staff providing services.

Substantiated administrative rule violations that are cited 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. MA staff performs an on-site follow up review to verify remediation has occurred and that the SLP provider is in compliance with administrative rules. Ongoing non-compliance will 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, MA staff would assist customers in identifying possible relocation options, including transferring to another SLP residence. State long term care ombudsman also receives a copy of the SLP Complaint Referral Notice. Ombudsman can choose to attend the on-site review with MA staff, and/or perform their own investigation.

The MA's grievance procedure is documented in the "Supportive Living Program Resident Complaint Process Overview" document. The policies and procedures are compliant with 42 CFR 441.301(c)(7) and ensure the following:

- No punitive or retaliatory action is taken against a customer or an authorized representative for filing a grievance.
- The MA will review resolutions for which a customer is dissatisfied.
- No conflict of interest with individuals who make decisions on grievances.
- The process provides the customer with the opportunity to present evidence and testimony either face-to-face (including through the use of audio or video technology) or in writing.
- The MA will provide the customer with their case file, other documents, or evidence related to or considered in reviewing the grievance at no cost to the customer.
- The MA will maintain grievance records including: description of reason for grievance, date received, date of each review, resolution of grievance, date of resolution, and name of customer.

MA staff will acknowledge receipt of the complaint within 10 business days in writing.

Grievances must be resolved within 90 calendar days from the date the MA receives the grievance. If more than 90 calendar days is needed to resolve a grievance and it is in the best interest of the customer or the customer requested an extension, the MA will inform the customer of the need for an extension. There may be up to a 14-calendar day extension to resolve the grievance. Prior to the 90-calendar day deadline, and within 2 business days of determining the need for an extension, the assigned staff will complete and send written communication of the extension with a summary of the complaint, reason for delay that is in the customer's best interest, and new deadline to the customer.

Upon resolution of the issue, the assigned staff will complete and send the written notice within the 90-calendar day timeframe, unless extended.

If a customer is not satisfied with the resolution, they may resubmit their grievance. Resubmittals will be assigned to a different staff person within the MA for re-review. Within 90 calendar days, the assigned staff will review the grievance. The new assigned staff will collect information and documentation from the relevant parties. The assigned staff will work with all parties towards the resolution. Upon resolution of the issue, the assigned staff will complete and send written notice to the customer.

For customers enrolled in a Managed Care Organization (MCO), grievances and complaints are handled through the MCO. A customer may submit his or her grievance orally or in writing, using any method of communication they prefer. An explanation of how to file a grievance is included in all customer handbooks. Examples of grievances include complaints about a provider (a provider or staff member did not respect his/her rights), trouble getting an appointment with his/her provider in an appropriate amount of time, or the customer was unhappy with the quality of care of services

he/she received. Customers can also file a grievance if an MCO staff person was rude or insensitive about the customer's cultural needs or other special needs. At any time during the grievance process, the customer can have someone represent or act on the customer's behalf. The MCO must acknowledge the receipt of the grievance within 48 hours. The MCO has no longer than 90 days to resolve the grievance; the MCO may inform the customer of their decision verbally or in writing.

CONTINUED IN MAIN B OPTIONAL

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 MA has reporting requirements and follow-up procedures for critical incidents. These apply to both fee-for-service customers and those enrolled in an MCO. The MCOs also have their own systems for reporting and follow-up on non-critical incidents. These requirements and processes are described below.

The 89 Ill. Adm. Code 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 customers, personnel and others present in the Supportive Living Program (SLP) setting. Additionally, 89 Ill. Adm. Code 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 as the result of actions by a staff member, family member, visitor or another customer. All of these incidents must be reported to the MA within 24 hours of occurrence (89 Ill. Adm. Code 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 SLP 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 SLP manager or designee must provide a preliminary report to the Department by fax within 24 hours after the occurrence". When a customer is harmed during an emergency (as defined above), the SLP provider must inform the customer's physician and the designated representative (89 Ill. Adm. Code 146.245(h), "The SLP 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 SLP 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 customers 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. MA 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 may be obtained as applicable.

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

MCOs must comply with both the Adult Protective Services Act and the Critical Incident reporting requirements. MCOs must comply with all health, safety, and welfare monitoring and reporting required by State or federal statute or regulation, or that is a condition for a HCBS Waiver, including the following: critical-incident reporting regarding abuse, neglect, self-neglect, and exploitation; critical-incident reporting regarding any incident that has the potential to place a customer, or a customer's services, at risk, but which does not rise to the level of abuse, neglect, or exploitation; and performance measures relating to the areas of health, safety, and welfare and required for operating and maintaining an HCBS Waiver.

Examples of critical events may include but are not limited to:

- Death
- Falls
- Serious physical injury or abuse
- Hospital admission
- Misuse of funds
- Medication error
- Unauthorized use of restraint, seclusion or restrictive physical or chemical restraints
- Elopement or missing person
- Fires
- Possession of firearms (customer or staff)
- Criminal victimization
- Financial exploitation

- Suicide or attempted suicide

For these types of incidents, if there is a perceived immediate threat to a customer's life or safety, the MCO will follow emergency procedures which may include calling 911.

SLP providers are required to submit critical incident reports involving MCO customers to the MCOs. All incidents will be reported to the compliance officer or designee and entered the MCOs CI report database. Based on situation, the customer's age and placement reports will also be made to the appropriate State of Illinois investigative agencies.

Rules may be accessed at the MA's website at:

<https://hfs.illinois.gov/medicalprograms/slf/slfrule.html>

- 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 Ill. Adm. Code 146.250(e), in the resident contract (89 Ill. Adm. Code 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 customer or his/her designated representative must review and sign the resident contract prior or at the time of admission. The MA reviews SLP provider resident contracts to ensure resident rights information is included. Additionally, the MA requires SLP providers to supply all customers with a "Hotline Information and Residents Rights" brochure at the time of admission. This brochure lists all of the rights customers have in the SLP and also offers the toll-free complaint hotline phone number. Resident rights information must also be provided annually at the time of the customer's required assessment. Additionally, SLP providers must display posters of the MA's toll-free complaint hotline and long-term care ombudsman program posters.

SLP providers must also encourage families of customers with impairments that limit the customer's decision-making ability to arrange to have a responsible party or guardian represent the customer's interests (89 Ill. Adm. Code 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").

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

SLP provider staff receive required training for resident rights and identifying and reporting abuse, neglect and exploitation. Training is required within 30 days of beginning employment and every year thereafter. MA staff review training documentation for all SLP provider staff during annual certification reviews.

For MCOs, customers are provided information about how and to whom to report abuse, neglect, self-neglect, and exploitation during assessments and reassessments. The MCOs provide the customer, or their family or representatives, information about their rights, signs of ANE, what to do if they suspect ANE, and protections, including how they can safely report an event and receive the necessary intervention or support. This happens at least annually, during either telephonic or face-to-face assessments.

The MCO must train their Care Coordinators and their external-facing employees on ANE and critical incidents. This includes network providers and subcontractors, who must be able to recognize potential concerns related to abuse, neglect, self-neglect, and exploitation. MCOs must also train those entities on their responsibility to report suspected or alleged abuse, neglect, self-neglect, or exploitation. MCOs train entities at outset on these subjects, can retrain when necessary, and post all material online for providers to review. Online material includes how to report ANE to appropriate authorities. Training sessions are customized to the target audience. Trainings include general indicators of ANE and the time-frame requirements for reporting suspected ANE.

- 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 MA receives critical incident reports. Customer abuse, neglect and exploitation (ANE), serious injuries that require medical intervention and/or result in hospitalization, criminal victimization, death (other than by natural causes), and other incidents or events that involve harm or risk of harm to a customer are reported by Supportive Living Program (SLP) providers to the MA (89 Ill. Adm. Code 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 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 customer'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 customers or missing customers, and any crime that occurs on SLP property". An incident report must be submitted to the MA within 24 hours of the occurrence.

The MA reviews incident reports and determines if further follow-up is required according to established procedures. All follow-up is conducted by the MA. The need for a follow-up review for critical incidents is determined based on the severity of the incident and the impact on customers, particularly their health and safety.

MA staff conduct the on-site review within the next working day of being notified by supervisory MA staff, or sooner if instructed. The review process may include examination of the physical structure of the SLP setting, interviews with customers and staff, customer 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 MA supervisory staff so that customer 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 MA issue may issue findings of non-compliance. The SLP provider is presented the findings in writing. A plan of correction must be submitted to the MA within fourteen days of receiving the findings of non-compliance. The plan must be implemented within thirty days. MA 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, MA staff would assist customers with relocation, including transfer to another SLP residence.

Additionally, if customers' current health or safety were threatened as the result of the SLP provider's response to the critical incident, the MA would issue an immediate jeopardy. Immediate jeopardy results in MA staff staying on-site at the SLP provider setting 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. MA staff performs an on-site follow-up review to determine if remediation has occurred. If continued non-compliance exists, the MA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement is terminated, MA staff would assist customers with relocation, including transferring to another SLP residence.

Customers and their families are able to obtain information related to on-site reviews of critical incident reports by contacting the MA 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. MA legal staff reviews all requests from customers or families and FOIA responses to verify compliance with HIPAA.

MCOs must comply with Critical Incident reporting requirements found in the SLP Waiver for incidents and events that do not rise to the level of abuse, neglect, self-neglect, or exploitation. The MCOs have similar processes and procedures in place to receive reports, to monitor, and to track and resolve Critical Incidents. Critical events and incidents must be reported and identified issues routed to the appropriate department within the MCO and when indicated to the investigating authority described above. The procedures include processes for ensuring customer safety while the State authority conducts its investigation.

MCOs maintain an internal reporting system for tracking the reporting and responding to Critical Incidents, and for analyzing the event to determine whether individual or systemic changes are needed. MCOs must comply with decision

made by the investigating authority.

- 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 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 Medicaid Agency (MA) and Managed Care Organizations (MCO) are responsible for detecting the use of unauthorized restraints and assuring customers' health, safety, and welfare. The use of unauthorized restraints is monitored through annual face-to-face visits, and through reports by providers, family or friends, as well as through the analysis of complaints or incidents.

MA oversight activities for fee-for-service and customers enrolled in a MCO include:

1. Review of all critical incident reports.
2. Annual certification reviews and complaint investigations.
3. Review instances of the unauthorized use of restraints.
4. During Quality Improvement reviews, the MA will review substantiated instances of the unauthorized use of restraints.

If a Supportive Living Program (SLP) provider was using unauthorized restraints with customers, the MA 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. MA staff performs an on-site follow-up review to verify the use of unauthorized restraints was no longer being practiced. If non-compliance persists after a second follow-up review, the MA implements sanctions, up to and including suspending or terminating the Medicaid provider agreement. If a Medicaid provider agreement was terminated, MA staff would assist customers with identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a customer's health or safety was threatened by the use of unauthorized restraints, the MA would issue a notice of immediate jeopardy. If a customer is at risk at the time of the on-site review, MA 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. MA 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 the potential for immediate jeopardy still exists, the MA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement is terminated, MA staff would assist waiver customers with identifying possible relocation options, including transferring to another SLP provider.

For customers enrolled in an MCO, the MCOs are responsible to detect the unauthorized use of restraints. Events involving the use of unauthorized restraints are reported to the MCO as reportable incidents and reported to the MA.

The MCOs detect unauthorized use of restraints through face-to-face visits, routine contacts with customers, and through complaint or incident reporting. The case coordinators are responsible for overseeing customers 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 Medicaid Agency (MA) and MCOs are responsible for detecting the unauthorized use of restrictive interventions and assuring customers' health, safety and welfare. The unauthorized use of restrictive interventions is monitored through annual face-to-face visits and through reports by providers, family, or friends, as well as through the analysis of complaints or incidents.

An oversight activities for fee-for-service and customers enrolled in a MCO include:

1. Review of all critical incident reports.
2. Annual certification reviews and complaint investigations.
3. Review instances of the unauthorized use of restraints.
4. During Quality Improvement reviews, the MA will review substantiated instances of the unauthorized use of restrictive interventions.

If a Supportive Living Program (SLP) provider was using unauthorized restrictive interventions, the MA 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. MA staff performs an on-site follow-up review to verify the use of unauthorized restrictive interventions is no longer being practiced. Follow-up reviews are unscheduled. If non-compliance persists after a second follow-up review, the MA would impose sanctions, up to and including suspending or terminating the Medicaid provider agreement. If a Medicaid provider agreement was terminated, MA staff would assist waiver customers with identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a customer's health or safety was threatened by the use of unauthorized restrictive interventions, the MA would issue a notice of immediate jeopardy. If a customer is at risk at the time of the on-site review, MA 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. MA 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 the potential for immediate jeopardy still exists, the MA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement was terminated, MA staff would assist customers with identifying possible relocation options, including transferring to another SLP provider.

Dementia program customers' safety needs may be met with a service intervention of delayed egress. When the exit door's release bar is pushed, an alarm sounds. The door will open if the bar is pushed for several continuous seconds.

Participation in the dementia program is voluntary. The customer, 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 customer's individual characteristics and needs for care and support. Dementia customers have the freedom to move within the dementia care setting, including access to secured outdoor common space.

All dementia program customers must have an elopement risk assessment completed prior to admission and quarterly thereafter by a registered nurse to determine if delayed egress is a necessary safety intervention. This safety intervention must be included in the PCP. The need for delayed egress is not a requirement to receive dementia program services. If a customer is assessed to no longer require this intervention and does not wish to continue receiving services in the dementia program, SLP provider staff discusses options for community placement with the customer and his/her designated representative.

Dementia program customers who require delayed egress as a safety intervention are able to leave the dementia care setting at any time with staff, family or other designated individuals. Customers whose assessment does not identify the need for delayed egress as a safety intervention are allowed to leave the building independently at any time they choose. SLP provider activities include options both on-site and in the larger community. Dementia customers 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.

MA staff completes annual on-site certification reviews for the dementia program. MA staff reviews elopement risk assessments for a random representative sample of dementia program customers. MA staff verifies that customers

have been appropriately assessed for the needed safety intervention of delayed egress. They also confirm assessments were timely, complete and accurate. The PCPs of sample of customers are also reviewed by the MA and EQRO to verify the need for delayed egress is included, if applicable. Customer access to common areas is also verified. If program non-compliance is identified, the process outlined above for SLP providers is followed.

For customers enrolled in an MCO, the MCOs are responsible to detect the unauthorized use of restrictive interventions. Events involving the use of unauthorized use of restrictive interventions are reported to the MCO as reportable incidents and reported to the MA.

The MCOs detect unauthorized use of restrictive interventions through face-to-face visits, routine contacts with customers, and through complaint or incident reporting. The case coordinators are responsible for overseeing customers and assuring their health, safety, and welfare.

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

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

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

Appendix G: Participant Safeguards

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

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

- **The state does not permit or prohibits the use of seclusion**

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

The Medicaid Agency (MA) and MCOs are responsible for detecting the unauthorized use of seclusion.

A oversight activities for fee-for-service and customers enrolled in a MCO include:

1. Review of all critical incident reports.
2. Annual certification reviews and complaint investigations.
3. Review instances of the unauthorized use of seclusion.
4. During Quality Improvement reviews, the MA will review substantiated instances of the unauthorized use of seclusion.

If an SLP provider was found to be using unauthorized seclusion with customers, the MA 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. MA staff performs an on-site follow-up review to verify the unauthorized use of seclusion was no longer being practiced. If non-compliance persists after a second follow-up review, the MA issues a sanction, up to and including suspension or termination the Medicaid provider agreement. If a Medicaid provider agreement is terminated, MA staff assist waiver customers with identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a customer's health or safety was threatened by the unauthorized use of seclusion, the MA would issue a notice of immediate jeopardy. If a customer is at risk at the time of the on-site review, MA 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. MA 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 the potential for immediate jeopardy still exists, the MA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement is terminated, MA staff would assist customers with identifying possible relocation options, including transferring to another SLP provider.

For customers enrolled in an MCO, the MCOs are responsible to detect the unauthorized use of seclusion. Events involving the use of unauthorized use of seclusion are reported to the MCO as reportable incidents and reported to the MA.

The MCOs detect unauthorized use of seclusion through face-to-face visits, routine contacts with customers, and through complaint or incident reporting. The case coordinators are responsible for overseeing customers 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)

• **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 customers who choose to receive medication management services.

Information regarding customer 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 customer'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 customer's condition.

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

Additionally, a Medicaid Agency 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 customer's physician and a plan of correction. For customers enrolled in a MCO, the SLP provider must notify the MCO 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.

(a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications);

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

During the record review, MA staff makes sure the customer's assessment corresponds with the person centered plan (PCP) and the correct medication management service is identified. MA staff also verifies that PCPs are implemented and that customers 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 MA staff to verify they were completed as required, physician notification occurred and a plan of correction to prevent errors in the future was included.

(b) the method(s) for following up on potentially harmful practices;

If MA 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. MA 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, MA staff would assist customers with identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a customer's current health or safety were threatened as the result of a medication management services not being provided appropriately, the MA would issue a notice of immediate jeopardy. If the customer is at-risk at the time of the on-site review, MA 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. MA staff perform an on-site follow up review to determine that remediation has occurred and the provider is in compliance with administrative rules. If the potential for immediate jeopardy still exists, the MA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement is terminated, MA staff would assist customers with identifying possible relocation options, including transferring to another SLP provider.

(c) the state agency (or agencies) that is responsible for follow-up and oversight.

The Medicaid agency is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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)*
 - **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 customer 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 Ill. Adm. Code 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 customers 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.

Amendment IL.0326.R05.03, effective 1/1/25, or upon CMS approval.

Certified Medication Aides may administer medications under the supervision and delegation of a registered nurse, who will be present in the SLP building, as authorized in Section 50-75 of the Illinois Nurse Practice Act, except where (i) Schedule II controlled substances as set forth in the Illinois Controlled Substance Act and (ii) any subcutaneous, intramuscular, intradermal, or intravenous medication.

- **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:

Medication errors that result in medical intervention, hospitalization, or death must be reported in writing to the Medicaid Agency (MA) within 24 hours on the Medication Error Report form. All other errors are recorded on the Medication Error Report form and made available to the MA at its request.

The Medication Error Report form documents medication errors related to administration of medication other than as prescribed, resulting in the wrong medication being given; the medication being given at the wrong time, in the wrong dosage, given to the wrong person, given via the wrong route, or by the wrong person; or medication omitted entirely.

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. The MA is responsible for the review and response to medication error reporting.

For participants enrolled in an MCO, the MCOs have processes for receiving medication error reports. The MCOs 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 customer safety.

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

Medication errors must be reported for customers who receive medication management services from the Supportive Living Program provider. These services include medication set-up, verbal reminders and administration. The Medicaid Agency (MA) 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 MA's request.

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

Medication errors that result in medical intervention, hospitalization, or death must be reported in writing to the Medicaid Agency (MA) within 24 hours on the Medication Error Report form.

The Medication Error Report form documents medication errors related to administration of medication other than as prescribed, resulting in the wrong medication being given; the medication being given at the wrong time, in the wrong dosage, given to the wrong person, given via the wrong route, or by the wrong person; or medication omitted entirely.

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:

- **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.

Medicaid Agency (MA) staff monitors medication management services received by customers annually during on-site certification reviews and also continuously and ongoing in response to complaints and Medication Error Reports received. During on-site reviews, the records of customers are reviewed, including documentation of medication management services and physician's orders, as well as Medication Error Reports. MA staff verifies customers 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. MA staff also verifies that medication administration is performed only by licensed nurses. Customers and Supportive Living Program provider staff are also interviewed. MA staff can observe the delivery of medication management services, if necessary.

Amendment IL.0326.R05.03, effective 1/1/25, or upon CMS approval.

Certified medication aides may administer medications under the supervision and delegation of a registered nurse, who will be present in the SLP building, as authorized in Section 50-75 of the Illinois Nurse Practice Act, except where (i) Schedule II controlled substances as set forth in the Illinois Controlled Substance Act and (ii) any subcutaneous, intramuscular, intradermal, or intravenous medication.

In addition to MA oversight for identification of problems in provider performance described above, MA staff will also monitor for compliance with required certification, registered nurse presence in the SLP provider building during certified medication aides administration of medication and compliance with the types and methods for medication administration allowed.

If an SLP provider was found to be out of compliance with requirements related to medication administration, the MA 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. MA staff performs a follow-up review to verify medication administration compliance. If non-compliance persists after a second follow-up review, the MA issues a sanction, up to and including suspension or termination of the Medicaid provider agreement. If a Medicaid provider agreement is terminated, MA staff assist waiver customers with identifying possible relocation options, including transferring to another SLP provider.

Additionally, if a customer's health or safety was impacted by non-compliance with medication administration requirements, the MA would issue a notice of immediate jeopardy. If a customer is at risk at the time of the on-site review, MA staff remains at the SLP provider community 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 the receipt of the findings. MA staff perform a follow-up review to verify that remediation has occurred and that the SLP provider is in compliance. If the potential for immediate jeopardy still exists, the MA will suspend or terminate the Medicaid provider agreement. If a Medicaid provider agreement is terminated, MA staff would assist customers with identifying possible relocation options, including transferring to another SLP provider.

If medication administration non-compliance resulted in a medication error, A Medication Error Report form would have to be completed by the SLP provider. Medication errors that result in medical intervention, hospitalization, or death must be reported in writing to the MA within 24 hours on the Medication Error Report form. All other errors are recorded on the Medication Error Report form and made available to the MA at its request. Medication Error Reports that require submission to the MA are tracked on an ongoing basis for completeness and accuracy. Patterns and trends by provider and error type are also tracked on an ongoing basis.

Data regarding non-compliance related to medication administration is compiled on an ongoing basis. If a pattern or trend was identified, the MA would initiate quality improvement strategies, such as developing provider training and/or resource documents.

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.

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

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:

G1: Number and percent of records where the customer/representative (rep) received info. from the SLP/MCO about how and to whom to report unexplained deaths and A/N/E at the time of each assessment. N: Number of records where the customer/rep received info. from the SLP/MCO about how and to whom to report unexplained deaths and A/N/E at the time of each assessment. D: Total # of 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):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☒ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with +/-5% margin of error
☐ Other Specify:	☒ Annually	☐ Stratified Describe Group:

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

Data Aggregation and Analysis:

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

Performance Measure:

G2: # and % of unexplained deaths and substantiated incidents of A/N/E reported to the MA and MCO that were reviewed/invest. within the required timeframe. N: # of unexplained deaths and substantiated incidents of A/N/E reported to the MA and MCO that were reviewed/invest. within the required timeframe. D: Total # of unexplained deaths and substantiated cases of A/N/E reported to the MA and MCO.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:

G3: Number and percent of deaths related to a substantiated case of abuse or neglect (A/N) reported to the MA and MCO where appropriate actions were taken to address incident. N: Number of deaths related to a substantiated case of A/N reported to the MA and MCO where appropriate actions were taken to address incident. D: Total number of deaths related to a substantiated case of A/N.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Critical incident reports and MCO reports

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

	☐ Other Specify: 	

Data Aggregation and Analysis:

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

- 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:

G4: Number and percent of critical incident trends where systemic intervention was implemented. Numerator: Number of critical incident trends where systemic intervention was implemented. Denominator: Total number of critical incident trends.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Critical incident reports and MCO reports

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

Data Aggregation and Analysis:

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

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:

G5: # and % of MA substantiated (substant.) incidents of confinement (restraint) and reported to the MCO where appropriate actions were taken to address the incident.

N: # of MA subst. incidents of confinement (restraint) and reported to the MCO where appropriate actions were taken to address the incident. D: Total # of MA substant. incidents of confinement (restraint) and reported to the MCO.

Data Source (Select one):

Other

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:

G6: Number and percent SLP staff who received training on alternative practices to restrictive interventions, including restraint and seclusion (R&S). Numerator: Number of SLP staff who received training on alternative practices to restrictive interventions, including R&S. **Denominator:** Total number of SLP staff.

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

	☐ Other Specify: 	
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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):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

G7: Number and percent of dementia program customers who had an elopement risk assessment completed according to program requirements. Numerator: Number of dementia program customers who had an elopement risk assessments 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):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒ Less than 100% Review

☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with +/-5% margin of error
☐ Other Specify: 	☒ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measure:

G8:# and % of dementia customers offered referral info. to another setting when the elopement risk assess. (ERA) did not show a need for delayed egress intervention. N: # of dementia customers offered referral info. to another setting when the ERA did not show a need for delayed egress intervention. D: Total # of dementia customers requiring referral info. to another setting that were reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	☐ 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):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

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

Performance Measures

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

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

Performance Measure:

G9: Number and percent of customers who reported being treated well by direct support staff. Numerator: Number of customers who reported being treated well by direct support staff. Denominator: Total number of customer respondents reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Customer interviews

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

Data Aggregation and Analysis:

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

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

Performance Measure:

G10: Number and percent of customers reporting they visited a doctor or practitioner for an annual screening within the last 12 months. Numerator: Number of customers reporting that they visited a doctor or practitioner for an annual screen within the past 12 months. Denominator: Total number of customer records 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):
☒ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☒ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☒ Representative Sample Confidence Interval = 95% confidence level with +/-5% margin of error

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

Data Aggregation and Analysis:

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

Performance Measure:**G11: Number and percent of medication errors reported to the MA as required.****Numerator: Number of medication errors reported to the MA as required.****Denominator: Total number of medication errors requiring reporting to the MA.****Data Source (Select one):**

Other

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly

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

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

The Medicaid Agency (MA) has a three-prong approach to address health, safety and welfare issues.

First the MA obtains a direct report of potential issues affecting health and safety from the customers. MA staff complete resident interviews during annual certification reviews, complaint investigations and incident report follow up reviews. These interviews help identify unmet needs and identify customer satisfaction. Some questions on the annual certification review tool identify customer's perceptions of safety, privacy and respectful treatment. If the MA substantiates non-compliance related to resident safety, privacy or not being treated with respect, findings may be issued, as detailed in sections G1-G3.

Second, the MA's approach screens-out potential workers with criminal backgrounds who seek employment with SLP providers. All Supportive Living Program (SLP) staff must undergo criminal background checks in compliance with state requirements for professional licensure or the Health Care Worker Background Check Act. Professionally licensed staff undergo criminal background checks as a condition of licensure. Unlicensed staff have background checks completed with results reported to a statewide Registry maintained by the Illinois Department of Public Health. The MA audits for compliance during annual certification reviews and complaint investigations.

Finally, the approach maintains a system to intervene and remediate reported incidents and complaints. The MA maintains an Event Report system to deal with critical incidents or complaints involving waiver customers. A critical incident includes a range of defined events that negatively impact the health and welfare of a waiver customer. A complaint includes any oral or written communication by the customer or other interested party expressing dissatisfaction with the operation or provision of service, service quality, service staff, or a failure to provide/offer services.

Any person can report a critical incident or make a complaint by contacting the MA's Supportive Living Program (SLP) Complaint Hotline or Health Benefits Hotline. The MA maintains a database of all complaints received and outcomes. After a complaint is received, MA staff complete an investigation. If the report includes suspected abuse, neglect, or exploitation by SLP staff, local law enforcement is contacted. If a SLP provider is determined to be out of compliance with program rules, findings may be cited, as detailed in sections G1-G3.

The MA has developed a protocol to deal with reports of critical incidents and complaints. The protocol defines timelines, notification requirements, referrals, and follow up steps. All critical incidents and complaints must be resolved within State set timelines, unless there are documented circumstances that preclude a resolution within this timeline.

The MA conducts routine programmatic and fiscal monitoring for both the SLP providers and the MCOs.

For those functions delegated to the MCOs, the MA is responsible for oversight and monitoring to assure compliance with

federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by the MCOs.

The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples from the fee for service and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a +/-5% margin of error. The MA pulls the sample annually and adjust the methodology as additional MCOs are enrolled to provide long term services and supports. For critical incidents, the MCOs are required to report 100% of the findings and remediation. These reports are summarized by the MCOs and reported at least quarterly to the MA.

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

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

G1: The Medicaid Agency (MA)/MCO will assure that customers know how to report abuse, neglect or exploitation. This will be demonstrated by collection of documentation reflecting customer's awareness, including evidence of steps taken to educate the customer. Remediation must be completed within 30 days.

G2: The MA/MCO will follow up all substantiated incidents. Changes in customer's PCP, corrective action plans or provider sanctions will be made when needed. Any immediate health and safety issues are abated. Resolution or remediation timeframe would be case-specific.

G3: The cause of death/circumstances would be reviewed by the MA and MCO and need for training or other remediation including sanction or termination of provider, would be determined based on circumstances and identified trends and patterns. Resolution or remediation timeframe would be case-specific.

G4: The MA/MCO will review all outstanding critical incidents to identify trends and implement systemic interventions, that may include training, a plan of correction, or other remediation to assure that critical incidents are being analyzed to determine root cause.

G5: The MA/MCO will follow up all substantiated incidents of confinement. Changes in customer's PCP, corrective action plans or provider sanctions will be made when needed. Resolution or remediation timeframe would be case-specific.

G6: The MA will follow up to ensure training is provided on alternative practices to restrictive interventions, including restraints and seclusion, in accordance with procedures for issuing findings of non-compliance.

G7: The MA will follow up to verify an elopement risk assessment is completed at the time non-compliance is identified.

G8: The MA will follow up to verify referral information to another setting is provided at the time non-compliance is identified.

G9: The MA will follow up on non-favorable interview responses. If identifying information is available for customer surveys, the MCO Care Coordinator will follow up on non-favorable surveys. Resolution or remediation will be based on the nature of the concern. Patterns of negative responses, including anonymous survey responses, will be used to identify need for system improvement.

G10: The MA or the MCO Care Coordinator will ask whether customer has a primary care doctor or practitioner and whether they had a physical in the last 12 months. If not, barriers will be identified and addressed. Remediation will occur at the meeting between the customer and MA or the MCO Care Coordinator.

G11: The MA will follow up to verify medication error reports are submitted to the MA at the time the non-compliance is

identified.

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>):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☒ Other Specify: MCO	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

☒ No

☐ Yes

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

Appendix H: Quality Improvement Strategy (1 of 3)

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

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

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

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

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement**a. System Improvements**

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

The Medicaid Agency (MA) and Managed Care Organizations (MCOs) work in partnership to evaluate the waiver Quality Management System (QMS). This partnership provides analysis to information derived from discovery and collaboratively develops and monitors remediation activities for each of the federal assurances.

The MA is responsible for the overall development and implementation of the QMS. This includes tracking changes across the entire state as well as by region and provider. This helps to identify problematic areas and potential best practices. The MA aggregates information and generate reports.

The MA takes a multi-phased and multilevel approach to using management reports to improve the overall system. Because changes in the compliance level for a performance measure may be explained by an external factor that would not require remediation, the first step is to investigate to try to determine if an actual problem exists. The second step is to formulate potential interventions that may remediate the problem. The third step is to roll out those interventions, possibly on a pilot basis. The final step is to track changes using the original performance measures to assess the impact of intervention.

The MA and MCO's are responsible for data collection to address the Quality Management System discovery and remediation activities. The MA is specifically accountable for the measures in the Administrative Authority appendix. The Administrative Authority appendix include performance measures for both the MA and the MCOs. Both the MA and the MCOs are accountable for all other measures. The state's system improvement activities are in response to aggregated and analyzed discovery and remediation data collected on each of the waiver performance measures.

On a quarterly basis, the MA conducts separate Quality Management Committee (QMC) meetings with the SLP waiver staff and the MCOs to review data collected from the previous quarter and for the year to date. Data is collected on a regular basis and is reported as indicated by the performance measure in the waiver. Annual reports are produced identifying trends based on the representative sample and/or 100% review of data. Data is reported by individual performance measures.

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

The MA also has a quality workgroup that assists with the QMS development, processes, and implementation. The workgroup is a collaboration of MA staff, other state agency staff, SLP providers, trade association staff, and long term care ombudsman. Members review QMS data and reports compiled by the MA to assist with system improvements. The quality workgroup meets annually. Members may also meet in smaller teams to focus on specific quality measures.

ii. System Improvement Activities

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
☒ Sub-State Entity	☒ Quarterly
☒ Quality Improvement Committee	☒ Annually
☐ Other Specify: 	☒ 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 processes Illinois follows to continuously evaluate, as appropriate, effectiveness of the QMS are the same as the processes to evaluate the information derived from discovery and remediation activities. The state tracks changes in the performance measures using data analysis and reports. Performance system design changes are monitored by the MA 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, the Medicaid Agency (MA) and quality workgroup may develop a proposed system change(s). The MA and quality workgroup discuss the changes to be implemented, which data sources will be used and how improvement will be measured.

Effectiveness is measured by impact on performance based on ongoing data collection over time, feedback from customer/guardian interviews and service providers. Multiple years of data collection will allow the MA to evaluate the effectiveness of system improvements over time.

System design changes may be specific to the MA or MCOs. Meeting with all parties annually provides an arena to see the system holistically and determine how well the system design changes are working and what areas need further improvement. Decisions that are made as a result of these meetings will be tracked on the QMC Systems Improvement Log.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

One QMC meeting a year is a combined meeting where the Medicaid Agency (MA) and the MCOs meet and discuss statewide issues impacting the waiver. During this annual meeting, the OA and the MCOs will provide an overview of the previous year's activities and a discussion of whether changes are needed to the Quality Management Strategy. There will be five primary focus areas. These areas are described below.

- 1) Structure of the QMC: The group reviews the structure of the QMC to determine if it is effective.
- 2) Trend Analysis: The group will evaluate the processes for identifying trends and patterns to assure that issues are being identified.
- 3) Systems Improvement Log: The group reviews the QMC Systems Improvement Log to assure that all recommendations have been implemented in accordance with agreed upon timelines, and if not, whether there is justification.
- 4) System Improvement Priorities: The methods for determining system improvement priorities is evaluated to determine its effectiveness.
- 5) Performance Measures: The entities will determine whether to make changes in existing performance measures, add measures, or discontinue measures. Other elements of performance measures will also be reviewed for effectiveness, including: the frequency of data collection, source of data, sampling methodology, and remediation.

The MA will continually strive to increase the compliance rate of each performance measure. While the target compliance rate for each performance measure is 100%, the State realizes that it may take multiple system changes over several years to reach the goal of 100% compliance.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

- ☒ No
- ☐ Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

- ☐ HCBS CAHPS Survey :
- ☐ NCI Survey :
- ☐ NCI AD Survey :
- ☐ Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) requirements concerning the independent audit of provider agencies

SLP providers are not required to submit an independent audit of their financial statements, however this must be provided to the MA upon request.

(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.

Supportive Living Program (SLP) providers rates are set by the Medicaid Agency (MA). A flat rate is paid for all services provided each day a Medicaid customer resides in a SLP provider setting.

SLP providers submit electronic claims each month to the MA for Medicaid customers not enrolled in a Managed Care Organization (MCO) 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 customer 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 customers who have been admitted to a SLP provider setting, per review and approval by DHS staff. This review also ensures the correct daily reimbursement rate is paid.

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 MA. The MA's Bureau of Health Finance audits the cost reports and maintains the historical cost information.

The MA'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 audit of 100% 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 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. At each provider review a statistically valid representative sample (using 95% confidence level and a +/-5% margin of error) of services for which the provider received payment for the audit period in question is reviewed. The audit process does not differ in any way by service or provider.

All services for which charges are made to the MA are subject to audit. Criteria reviewed includes room and board ledgers, required MA transactions related to payment generation, disbursement of customer personal allowance, temporary absences, and customer 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. During a review audit, the provider must furnish to the MA'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 MA's OIG conducts field audits of SLP providers. Field audits employ algorithms that analyze data that cannot be automatically validated, thus requiring a manual review of provider documentation. An onsite review can be triggered in several situations, for example if a SLP provider has tried to double and triple bill for the same month or for the same customer and bill for customers no longer being served or who were never being served.

The MA's procedure for auditing providers can involve the use of sampling and extrapolation. Under such a procedure, the MA selects a statistically valid sample representative sample (using 95% confidence level and a +/-5% margin of error) 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 MA the entire extrapolated amount of incorrect payments calculated under this procedure after Final notice and/or an opportunity for hearing. The state does not require corrective action plans.

When inappropriate claims are identified, the OA and MCOs work with the provider to correct their billing. Voided claims reduce the state's claim for FFP through an adjustment process. If the correction includes a recoupment, the collection occurs through future billings submitted by the provider until the money is recouped.

The MA's OIG has the legal authority to perform an audit of Medicaid providers 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. Audit results are emailed to the provider.

For customers enrolled in an MCO, the MA's internal and external auditing procedures will ensure that payments are made to an MCO only for eligible customers who have been properly enrolled in the waiver.

SLP providers are also paid by MCOs with which the MA contracts. The MCOs, through HealthChoice Illinois and the Medicare Medicaid Alignment Initiative (MMAI), receive monthly capitated payments from the MA and are responsible for managing and paying for the care of specific customers. 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 a customer's eligibility for SLP services. In addition, MCOs are required to submit their paid claims to the MA as encounter data that is processed through the MA's Medicaid Management Information System (MMIS) to verify that payments were paid appropriately to Medicaid eligible providers for eligible customers.

The MCOs are responsible for reviewing payments made directly to providers for waiver services as part of the HealthChoice Illinois/MMAI. The MCO must have an internal process to validate payments to waiver providers. This includes the claims processing system verifying a customer's waiver eligibility prior to paying claims.

(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).

30 ILCS 5/3 specifies the jurisdiction of the Auditor General and section 3-2 identifies the mandatory post audits. The Auditor General shall conduct a financial audit, a compliance audit, or other attestation engagement, as is appropriate to the agency's operations under generally accepted government auditing standards. In conjunction with HFS' portion of the Statewide Single Audit, a sample of provider billings for Medicaid payments that may include billings for Medicaid payments for waiver services is reviewed. The Illinois Office of Auditor General is responsible for conducting the financial audit program.

The MA's Office of Inspector General (OIG) has statutory authority, via Public Act 97-0689, to oversee the integrity of the Illinois Medicaid program in order to prevent, detect and eliminate fraud, waste and abuse.

EVV does not apply to the SLP waiver. PCS and HHCS are not provided billable services through the waiver.

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.

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

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:

I1: Number/percent of payments that were paid for customers who were enrolled in the waiver on the date the service was delivered. Numerator: Number of payments that were paid for customers who were enrolled in the waiver on the date the service was delivered. Denominator: Total number payments reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MCO reports, MMIS Medical Data Warehouse

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

	☐ 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):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

Performance Measure:

I2: Number and percent of payments made for services rendered that were coded and paid in accordance with the reimbursement methodology in the approved waiver.

Numerator: Number of payments made for services rendered that were coded and paid in accordance with the reimbursement methodology in the approved waiver.

Denominator: Total number of payments reviewed.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MMIS, Encounter Data

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

☐ <i>Sub-State Entity</i>	☐ <i>Quarterly</i>	☐ <i>Representative Sample</i> Confidence Interval =
☐ <i>Other</i> Specify: 	☒ <i>Annually</i>	☐ <i>Stratified</i> Describe Group:
	☐ <i>Continuously and Ongoing</i>	☐ <i>Other</i> Specify:
	☐ <i>Other</i> 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):
☒ <i>State Medicaid Agency</i>	☐ <i>Weekly</i>
☐ <i>Operating Agency</i>	☐ <i>Monthly</i>
☐ <i>Sub-State Entity</i>	☐ <i>Quarterly</i>
☐ <i>Other</i> Specify: 	☒ <i>Annually</i>
	☐ <i>Continuously and Ongoing</i>
	☐ <i>Other</i> Specify:

- 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:

I3: Number and percent of rates that are consistent with the approved rate methodology throughout the five-year waiver cycle. Numerator: Number of rates that are consistent with the approved rate methodology throughout the five-year waiver cycle.

Denominator: Total number of rates.

Data Source (Select one):

Other

If 'Other' is selected, specify:

MA rate development report

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

	☐ 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):
☒ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☒ Quarterly
☐ Other Specify: 	☒ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

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

The Medicaid Agency (MA) is responsible for oversight and monitoring to assure compliance with federal assurances and performance measures. The MA monitors both compliance levels and timeliness of remediation by SLP providers and MCOs through fiscal monitoring and ongoing reporting by the MCOs.

The MA's sampling methodology is based on a statistically valid sampling methodology that pulls proportionate samples for fee for service and the enrolled MCOs. The proportionate sampling methodology uses a 95% confidence level and a +/-5% margin of error. The MA will pull the sample annually.

Monitoring of the use of the correct reimbursement rate requires review of claims data pulled from the Medicaid Management Information System (MMIS) and rate information provided by MCO reports. Claims are priced by procedure code. The MA 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.

Edits in the MA's MMIS prevent providers from billing the MA for duplicative services. The MA has duplicate claim checks for fee for service and encounter claims with 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 customer is admitted to another long term care provider, the SLP provider is required to discharge the customer in the MA's data interchange system. The new long term care provider enters an admission into the MA's data interchange

system. The Medicaid Management Information System (MMIS) does not allow a client to have an admission to an SLP provider and another long term care provider at the same time.

MMIS only allows payment to certified providers. The MA certifies SLP providers initially and annually. The MA also processes Medicaid provider enrollment. Until a SLP provider is certified and enrolled as a Medicaid provider by the MA, MMIS will not allow payments to be issued. When an SLP provider is terminated from the Medicaid program, MMIS prevents payment from being issued.

SLP providers receive a daily per diem and the MA's MMIS contains duplicate claim logic that will reject multiple claims for the same date of service. There are edits in the MA's MMIS to prevent providers from billing the MA for customers enrolled in an MCO. When a customer is enrolled in managed care, MMIS will not allow the MA to issue a payment for any services covered by the MCO, including waiver services. If a provider bills the MA for a customer enrolled in an MCO, the claim will reject with the "Recipient in MCO" message.

Additionally, the MCOs receive a monthly file from the MA with information about SLP customers. The report is generated from MMIS and includes MCO enrollment and SLP waiver eligibility. The MA's contract with the MCOs states payment should not be issued prior to confirmation the customer is included in the report.

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

Through its contract with the External Quality Review Organization (EQRO), the MA monitors both compliance of performance measures and timeliness of remediation for those waiver customers enrolled in an MCO through customer surveys and quarterly record reviews. Customers in MCOs are included in the representative sampling.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

I1: The Medicaid Agency (MA) will identify a non-allowable service period when an individual is not eligible for the waiver. MA staff will manually change or delete the admission date in the long term care database. This will result in the Medicaid Management System (MMIS) making an automatic adjustment to reduce a future payment to the SLP provider. The MA will adjust the federal claim for services provided by the MCO during a non-allowable service period. Remediation must be completed within 30 days.

I2: The MA will determine whether payments were issued in accordance with the reimbursement methodology. If paid incorrectly, the appropriate MA staff/MCO is notified and the federal claim is voided and resubmitted. Remediation must be completed within 30 days.

I3: The MA will correct the rate. If necessary, it will also adjust federal claims submitted. Remediation must be completed within 30 days.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☒ **No**

☐ **Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The public input process for the renewal of this waiver is detailed in Main Section 6-I.

The MA solicits public comments by means of a public notice when changes in methods and standards for establishing payment rates under the waiver are proposed. The notice published in accordance with Federal requirements at 42 CFR 447.205, which prescribes the content and publication criteria for the notice. The MA maintains a log of public comments and shares with the OA. If the OA receives a public comment, it shares with the MA. The log captures the commenter's entire submission. The MA and OA correspond to analyze the comment and develop a response summary. These records are electronically stored by the MA and are never deleted. These records can be shared electronically with CMS upon request.

Rate information is available on the MA's website at:

<https://hfs.illinois.gov/medicalproviders/medicaidreimbursement/supportiveliving.html>. The MA also has email inboxes for the Department as a whole, the Bureau of Long Term Care, which administers the waiver, and also for the Supportive Living Program (SLP). Toll free numbers for the Department and the SLP are available on the MA's website, Resident Rights brochures and complaint hotline posters. The website, various emails and phone numbers allow customers access to the MA to request information about rates.

The MA retains and exercises final authority over payment rates. SLP rates were initially set in July 2019 and last reviewed in 2023.

The reimbursement rate methodology for SLP providers is established by State statute. The daily rates for conventional SLP providers are set at 54.3% of the average total nursing facility services per diem for the geographic areas defined by the MA while maintaining the rate differential for dementia care and must be updated whenever the total nursing facility service per diems are updated, which is quarterly. It was determined that this methodology results in fair and acceptable rates for providers allowing them to provide required services and quality care, while at the same time ensuring cost neutrality in comparison with institutional care. The average total nursing services per diem rate shall include all add-ons for nursing facilities for the geographic area. The MA intends to work with stakeholders to incorporate a pathway for accountability in applying the add-ons similar to what is done for nursing facility add-ons. In reviewing the fixed unit rate of reimbursement, the MA takes into consideration (1) service utilization and cost information, and (2) current market conditions and trend analysis with the goal of ensuring customer access to high quality services.

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 customers' needs. Room and board rates, including meals, are paid directly by the customer to the SLP provider and are based on Supplemental Security Income amounts. These payments are separate from the MA 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.

MCOs are required to pay SLP providers at least the same daily rate as that of FFS customers.

Amendment IL.0326.05.01, effective 11/1/2023.

A \$6.15 per diem increase is being added to the daily rate for the provision of two (2) meals per day as part of the Appendix K unwinding. This rate is established based on two-thirds (2/3) of the of the average SNAP benefit for a single customer.

The state is using Section 9817 ARPA funds for the two meals. SLP providers will provide a third meal per day through room and board collections (non-Medicaid dollars). The State continues to explore options to fund this service provision beyond March 2025.

A \$2.59 per diem increase is being added for quality initiatives for staffing hours/resident day, unplanned hospitalizations and emergency department visits. The quality add-on rate payments are being implemented similarly to what is done for nursing facility add-ons. Data for the quality add-on rate payments will be collected and applied

prospectively quarterly to the SLP providers' daily rate.

Amendment IL.0326.R05.02, effective 1/1/25.

The \$6.15 daily add-on for providing two (2) meals per day will be paid with General Revenue Funds upon the discontinuation of American Rescue Plan Act monies in April 2025.

The reimbursement rate will increase from 53.4% of the average total nursing facility services per diem for the geographic areas defined by the Medicaid Agency to 54.75%.

Amendment IL.0326.R05.04, effective 1/1/2027 or upon CMS approval:

In accordance with 42 CFR 447.203(b)(3), the State publishes a payment rate disclosure that details the payment rates by the average hourly Medicaid fee-for-service fee schedule payment rates at <https://hfs.illinois.gov/medicalclients/hcbs/hcbsaccessrulreporting.html>. The payment rate disclosure is organized by category of service, separately identifies the payments made to individual providers and provider agencies, identifies the geographic location for the which the rate is applicable, and provides claims and beneficiary volume. The State is currently developing a policy to ensure the payment rate disclosure is updated no less than every two years.

The MA publishes SLP payment rates. These are available from the MA's website at <https://hfs.illinois.gov/medicalclients/hcbs/hcbsratefeeschedules.html>. The SLP payment rates are organized in the same manner as the OA's, so that a member of the public can readily determine the amount Medicaid would pay for a given service. The template breaks down Illinois HCBS services and payment rates by 1. service/service description; 2. procedure code; 3. Modifier; 4. Geographic area; 5. Unit type; 6. Unit rate. The MA has a policy in place to ensure that each time a rate is updated, the MA will monitor OA websites to ensure updates occur within 30 days of a rate change. All OAs have the publication date listed on their fee schedules, and the MA confirmed all were published by July 1, 2026.

- 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 Medicaid Agency (MA). A flat rate is paid for all services provided each day a customer resides in a SLP provider setting. SLP providers submit electronic claims each month to the MA for customer 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 customer is in the SLP setting, temporary absence days and third party liability coverage. Claims are verified with information in the MA's Medicaid Management Information System (MMIS) long term care database to ensure payment is made for Medicaid eligible customers who have been admitted to a SLP provider setting, per review and approval by DHS staff. Billings are rejected if the customer is enrolled in a Managed Care Organization (MCO) and the provider will be directed to submit the bill to the appropriate MCO for reimbursement. Billings are also rejected if the customer is identified on the Social Security Administration's death record as deceased for the date of service. Additionally, a rejection will occur if the customer has an admission to another SLP provider community or nursing home for the same dates of service in the long term care database.

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.

Monthly capitated rates are paid by the MA to the MCO. This payment is generated by the MMIS based on the customer's eligibility for waiver services as identified in the database. The MCOs only receive payment for customers eligible for waiver services. The MCO payment process is automated to generate a monthly capitation to the MCOs based on the rate cell of each customer each month. The MA reviews to ensure the accurate rate is entered into the system, and spot checks payment reports to ensure payments are made correctly. In addition, the MCOs are required to review their monthly payment and report any discrepancies to the MA.

In general, the rate cells for the Medicaid Component are stratified by age (21-64 and 65+), geographic service area (Greater Chicago and Central Illinois) and setting-of-care. Capitation Rate updates will take place on January 1st of each calendar year. MCOs will be provided a rate report, to be signed by MA and MCO, on an annual basis for the upcoming calendar year.

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 customer's eligibility criteria to determine the appropriate rate cell to be used in generating the payment. As a result of this process, a file is created of MCO schedules which are then sent on to the Comptroller for payment. Once the payment has been made by the Comptroller, a file is sent back to the MA by the Comptroller that includes a warrant number and date. The MA then creates a HIPAA 820 files for each MCO. The 820 file contains the detailed payment information on each of the MCO's enrollees. The MCOs are required to have internal processes to validate payments to waiver providers. The MCO's claims processing system must verify a customer's waiver eligibility prior to paying claims.

The MCO payment process is automated to generate a monthly capitation to the MCO based on the rate cell of each customer, each month. The MA reviews to ensure the accurate rate is entered into the system, and spot checks payment reports to ensure payments are made correctly. In addition, the MCOs are required to review their monthly payment and report to the MA for discrepancies. Lastly, the MA performs post-payment financial reviews.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

- ☒ No. state or local government agencies do not certify expenditures for waiver services.
- ☐ Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

- ☐ Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

(a) when the individual was eligible for Medicaid waiver payment on the date of service;

Supportive Living Program (SLP) rates are set by the Medicaid Agency (MA). A flat rate is paid for all services provided each day a customer resides in a SLP provider setting. Claims are verified with information in the long term care database to ensure payment is made for Medicaid eligible customers who have been admitted to a SLP provider community, per review and approval by DHS staff. SLP providers submit electronic claims each month to the MA for Medicaid customers via the Department's Internet Electronic Claim system. Providers follow the UB04 and 837I Implementation guidelines to submit claims.

(b) when the service was included in the participant's approved service plan;

Claim information includes the dates a customer is in the SLP provider community, temporary absence days and third party liability coverage.

The SLP provider is responsible for entering customer discharges and deaths into the MA's data interchange system within fifteen days. Additionally, the MA'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 customer transfers to another long term care provider and the SLP provider does not enter this information in the data interchange system, DHS would become aware of the discharge when the new long term care provider submits admission information. Upon entry of the long term care admission information into the database, the MA would recover any payments made to the SLP provider after the customer's discharge. 89 Ill. Adm. Code 140.513 requires providers to notify the MA within fifteen business days of a change of resident status.

(c) the services were provided:

Hospital stays and vacations are reported to the MA as temporary absences. In the event a SLP provider does not notify the MA 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 customer 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 MA's Office of Inspector General audits for any payment made to an SLP provider for an individual with an overlapping inpatient hospital stay.

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.

Claims are verified with information in MMIS to ensure payment is made for Medicaid eligible customers who have been admitted to a certified, Medicaid enrolled, SLP provider setting, per review and approval by the Department of Human Services (DHS) staff. MMIS also includes edits to assure claims are not duplicative of nursing facility, hospital or Managed Care Organization (MCO) paid claims. 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 MA to the MCO. This payment is generated by the Medicaid Management Information Systems (MMIS) based on the customer's eligibility for waiver services as identified in the database system. The MCO payment process is automated to generate a monthly capitation to the MCOs based on the rate cell of each customer, each month. The MA reviews to ensure the accurate rate is entered into the system, and also spot checks payment reports to ensure payments are made correctly. In addition, the MCOs are required to review their monthly payment and report to the MA any discrepancies. Lastly, the MA performs post payment financial reviews.

The MCOs are required to have internal processes to validate payments to waiver providers. The MCO claims processing system must verify a customer's waiver eligibility prior to paying claims. The MCO payment process is automated to generate a monthly capitation to the MCOs based on the rate cell of each customer each month. The State reviews to ensure the accurate rate is entered into the system, and also spot checks payment reports to ensure payments are made correctly. In addition, the MCOs are required to review their monthly payment and report to the MA for discrepancies.

- 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

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) settings 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 customers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ☒ **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.

- ☐ **The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ☐ **The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 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 section 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 section 1915(b)/section 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 section 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 section 1115/section 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 section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ☐ **If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.**

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver 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 section 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.

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 Medicaid Agency for waiver services. Room and board costs are paid directly to the Supportive Living Program provider by the customer. 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**
- ☐ **Coinurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

- ☒ **No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ☐ **Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	26260.08	2138.77	28398.85	42946.60	2311.69	45258.29	16859.44
2	31003.44	2341.31	33344.75	47118.41	2529.97	49648.38	16303.63

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)
3	31835.76	2417.56	34253.32	48752.77	2611.25	51364.02	17110.70
4	32513.00	2486.64	34999.64	50240.54	2684.28	52924.82	17925.18
5	32941.86	2537.52	35479.38	51356.30	2737.12	54093.42	18614.04

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	14099		14099
Year 2	15246		15246
Year 3	15705		15705
Year 4	16245		16245
Year 5	17168		17168

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay (ALOS) estimate for each waiver year (WY) is equal to the projected total number of days participants will be enrolled in the Supportive Living Program (SLP) divided by the unduplicated participant count. The ALOS has been projected based on continuing SLP enrollment in MMIS from September 2017 through December 31, 2021 and phase-in and phase-out assumptions throughout the five-year waiver period. The enrollee phase-in and phase-out projections were based on the assumption that waiver participation will return to pre-pandemic levels by WY 1 and continue to grow at a similar rate as observed prior to the pandemic. In addition, projections reflect the addition of new SLP providers during the five-year waiver period. The ALOS is significantly lower for WY1 because 30 communities are expected to be certified on or around August 23, 2023, resulting in a significant number of participants with only one month of waiver enrollment in WY 1.

The phase-in/phase-out schedule has been entered into Attachment #1 to Appendix B-3,

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

In the development of this waiver renewal, previously submitted CMS 372 reports were not used as a basis because they do not contain sufficient detail to support projections. Instead, estimates were developed using claims and enrollment data in the State's Medicaid Management Information System (MMIS) through March 2022. Users, units, and paid amounts were summarized by waiver service separately for each waiver year between September 2017 and December 2021. These summaries are similar to 372 reports, except all runout is through March 2022 rather than 18 months.

Factor D estimates for each waiver year are the sum of expenditures for each waiver service divided by the number of unduplicated waiver participants for the waiver year. The expenditures for each waiver service are the product of the number of unduplicated waiver participants for the waiver year. The expenditures for each waiver service are the product of the number of unduplicated users, average units per user, and the average cost per unit.

--Unduplicated users: Unduplicated users for each waiver service were estimated by multiplying the percent of total unduplicated participants receiving each waiver service by the total unduplicated participant count for each waiver year. Assisted living is the only service provided under the Supportive Living Program (SLP) waiver, so the percent of total unduplicated participants receiving this service was assumed to be 100%.

--Average units per user: The average units per user was set equal to the average length of stay for each waiver year since the only service in this waiver is provided daily for all enrollees.

--Average cost per unit: The average cost per unit during WY 1 was based on applying SLP fee schedules effective April 1, 2022, and a one-time rate increase to reflect the passage of Nursing Home Rate Reform expected to take effect July 2022. The fee schedules were blended based upon the mix of services by region and dementia versus non-dementia care from September 2021 to January 2022, with adjustments to reflect the addition of new SLP providers prior to the end of WY 1. Further adjustments were also made for WY 2, WY 4 and WY 5 to reflect the addition of new SLP providers during those years. Additionally, a 2.5% annual unit cost trend was applied to the SLP per diem gross of patient liability. Trend rates were developed based on historical changes to gross nursing facility reimbursement because SLP fee schedules are directly proportionate to nursing facility fee schedules. SLP fee schedules from July 2017 through April 2022 were used to develop a 2.5% gross cost trend. For each waiver year, we subtracted projected patient liability from composite gross SLP rates to develop the average cost per unit projected in Appendix J-2-d.

Amendment IL.0326.05.02, effective 11/1/2023, or upon CMS approval.

A \$6.15 per diem increase is being added to the daily rate for the provision of two (2) meals per day as part of the Appendix K unwinding. This rate is established based on two-thirds (2/3) of the of the average SNAP benefit for a single customer.

The state is using Section 9817 ARPA funds for the two (2) meals. SLP providers will provide a third (3rd) meal per day through room and board collections (non-Medicaid dollars). The State continues to explore options to fund this service provision beyond March 2025.

A \$2.59 per diem increase is being added for quality initiatives for staffing hours/resident day, unplanned hospitalizations and emergency department visits. The quality add-on rate payments are being implemented similarly to what is done for nursing facility add-ons. Data for quality add-on rate payments will be collected and applied prospectively quarterly to the SLP providers' daily rate.

To account for these increases in waiver years 2 through 5, the average cost per unit is increased by \$8.74 (total per diem increase of the covered meals and quality initiative). In waiver year 1, the average cost per unit is increased by approximately \$2.19 to reflect the one quarter in which the rate increase will be effective.

Amendment IL.0326.R05.03, effective 1/1/25, or upon CMS approval.

The \$6.15 daily add-on for providing two (2) meals per day will be paid with General Revenue Funds upon the discontinuation of American Rescue Plan Act monies in April 2025.

The Assisted Living reimbursement rate will increase from 53.4% of the average total nursing facility services per

diem for the geographic areas defined by the Medicaid Agency to 54.75%.

- 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' is the average per capita non-waiver service cost for waiver participants. In the development of this waiver renewal, previously submitted CMS 372 reports were not relied upon because most waiver enrollees are in managed care. Estimates were therefore developed using CY 2022 HealthChoice and MMAI capitation rates along with claims and enrollment data in the State's Medicaid Management Information System (MMIS) through March 2022.

For members eligible for managed care, CY 2022 per member per month (PMPM) benefit expenses for non-waiver services reflected in the CY 2022 HealthChoice and MMAI capitation rates for Other Waiver rate cells were used. Costs for non-waiver services not covered in the capitation rates which were estimated during the CY 2022 capitation rate development were added. An acuity adjustment of approximately 0.857 was applied to the Disabled Adult (DA) - Other Waiver rate cell to reflect lower PMPM costs for SLP enrollees relative to the average member month in the DA-Other Waiver rate cell. Non-waiver costs are not materially different for dual eligible populations.

For members ineligible for managed care, CY 2019 non-waiver expenditures for Medicaid enrollees with an open SLP segment were summarized and divided by the applicable member months to develop a non-waiver PMPM benefit expense. These members had a cost profile similar to dual eligible managed care enrollees. Trend was applied for three years to project these costs to CY 2022. The trend rate is consistent with CY 2022 dual eligible capitation rate development.

To estimate Factor D' in WY 1, the CY 2022 PMPM non-waiver benefit expenses were trended forward to the midpoint of the waiver year. These PMPMs were multiplied by average length of stay and composited across rate cells and members ineligible for managed care using December 2021 SLP enrollment. The trend rates are consistent with CY 2022 capitation rate development. Future waiver years were projected by adjusting for the change in ALOS and applying an annual trend adjustment, consistent with the trend applied in project WY 1.

Estimates for Factor D' for each waiver year are illustrated in the cost neutrality summary in Figure 1. Factor D' is slightly less than Factor G' for each waiver year. The discrepancy is primarily attributable to the nursing facility population having higher inpatient utilization than the SLP population.

The factors are causing Factor G' to be significantly greater than Factor D' are related to the estimates for Factor D' and Factor G' were based on review of historical data for waiver (Factor D') and institutional (Factor G') populations. The institutional G' population has higher acute inpatient utilization and costs resulting in the variance between Factors G' and D', particularly for non-dual eligible members.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is the average per capita LTC institutional cost for LTC institutional recipients with a comparable level of care. For the SLP, this is individuals with a nursing facility level of care.

For members eligible for managed care, CY 2022 per member per month (PMPM) benefit expenses for LTC services reflected in the CY 2022 HealthChoice and MMAI capitation rates for Nursing Facility rate cells were used to develop the estimates. For members ineligible for managed care, CY 2018 through CY 2020 LTC expenditures for members who had a nursing facility claim and who were at least 21 years old were summarized and divided by the applicable member months to develop a LTC PMPM benefit expense. These members had a cost profile similar to dual eligible managed care enrollees. Trend was applied for three years to project these costs to CY 2022. The trend rate is consistent with CY 2022 dual eligible capitation rate development.

To estimate Factor G in WY 1, the CY 2022 PMPM LTC benefit expenses were trended forward to the midpoint of WY 1. Additionally, to reflect the passage of Nursing Home Rate Reform expected to take effect July 2022, a one-time rate increase was applied to gross nursing facility costs. These PMPMs were multiplied by the average length of stay and composited across rate cells and members ineligible for managed care using December 2021 SLP enrollment. The trend assumptions were based on trends and program changes for LTC services applicable to the Disabled Adult and MLTSS populations in CY 2022 capitation rate development. Future waiver years were projected by adjusting for the change in average length of stay and applying an annual trend adjustment consistent with the trend applied to project WY 1.

Estimates of Factor G for each waiver year are illustrated in the cost neutrality summary in Figure 1.

- 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 the average per capita non-LTC state plan service cost for LTC institutional recipients with a comparable level of care. For the SLP, this is individuals with a nursing facility level of care.

The factors are causing Factor G' to be significantly greater than Factor D' are related to the estimates for Factor D' and Factor G' were based on review of historical data for waiver (Factor D') and institutional (Factor G') populations. The institutional G' population has higher acute inpatient utilization and costs resulting in the variance between Factors G' and D', particularly for non-dual eligible members.

For members eligible for managed care, CY 2020 per member per month (PMPM) benefit expenses for non-LTC services reflected in the CY 2022 HealthChoice and MMAI capitation rates for Nursing Facility rate cells were used to develop the estimates. Costs for non-LTC services not covered in the capitation rates which were estimated during the CY 2022 capitation rate development were added. For members ineligible for managed care, CY 2018 through CY 2020 non-LTC expenditures for the members identified in Factor G development were summarized and divided by the applicable member months to develop a non-LTC PMPM benefit expense. Trend was applied for three years to project these costs to CY 2022. The trend rate is consistent with CY 2020 dual eligible capitation rate development.

To estimate Factor G' in WY 1, the CY 2022 PMPM non-LTC benefit expenses were trended forward to the midpoint of WY 1. These PMPMs were multiplied by the average length of stay and composited across rate cells and members ineligible for managed care using December 2021 SLP enrollment. The trend assumptions were based on trends and program changes for non-LTC services applicable to the Disabled Adult and MLTSS populations in CY 2022 capitation rate development. Future waiver years were projected by adjusting for the change in ALOS and applying an annual trend adjustment consistent with the trend applied to project WY 1.

Estimates of Factor G' for each waiver year are illustrated in the cost neutrality summary in Figure 1.

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 section 1915(b)/section 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:							370240867.92
Assisted Living	☒	Day	14099	232.00	113.19	370240867.92	
GRAND TOTAL: 370240867.92 Total: Services included in capitation: 370240867.92 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 14099 Factor D (Divide total by number of participants): 26260.08 Services included in capitation: 26260.08 Services not included in capitation: Average Length of Stay on the Waiver: 232							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							472678446.24
Assisted Living	☒	Day	15246	247.00	125.52	472678446.24	
GRAND TOTAL: 472678446.24 Total: Services included in capitation: 472678446.24 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 15246 Factor D (Divide total by number of participants): 31003.44 Services included in capitation: 31003.44 Services not included in capitation: Average Length of Stay on the Waiver: 247							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							499980610.80
Assisted Living	☒	Day	15705	248.00	128.37	499980610.80	
GRAND TOTAL: 499980610.80 Total: Services included in capitation: 499980610.80 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 15705 Factor D (Divide total by number of participants): 31835.76 Services included in capitation: 31835.76 Services not included in capitation: Average Length of Stay on the Waiver: 248							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Overview table.

Waiver Year: Year 4

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							528170436.00
Assisted Living	☒	Day	16245	248.00	131.10	528170436.00	
GRAND TOTAL: 528170436.00 Total: Services included in capitation: 528170436.00 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 16245 Factor D (Divide total by number of participants): 32513.00 Services included in capitation: 32513.00 Services not included in capitation: Average Length of Stay on the Waiver: 248							

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (9 of 9)****d. Estimate of Factor D.**

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assisted Living Total:							565545852.48
Assisted Living	☒	Day	17168	246.00	133.91	565545852.48	
GRAND TOTAL: 565545852.48 Total: Services included in capitation: 565545852.48 Total: Services not included in capitation: Total Estimated Unduplicated Participants: 17168 Factor D (Divide total by number of participants): 32941.86 Services included in capitation: 32941.86 Services not included in capitation: Average Length of Stay on the Waiver: 246							